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Referral, persistence in therapy and drop-out patterns of elderly clients in a community mental health center.

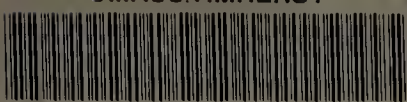
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REFERRAL, PERSISTENCE IN THERAPY AND DROP-OUT PATTERNS
OF ELDERLY CLIENTS IN A COMMUNITY MENTAL HEALTH CENTER

A Dissertation Presented

by

PEARL M. MOSHER-ASHLEY

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May, 1988

EDUCATION

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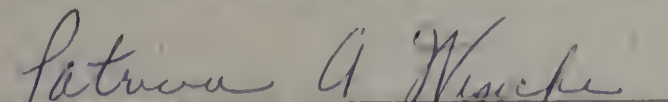
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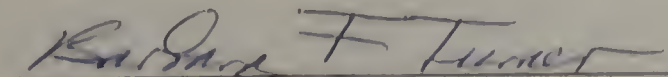
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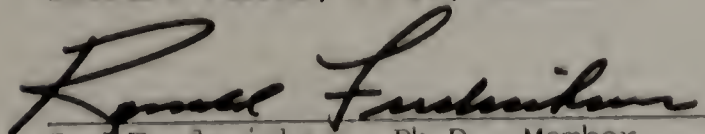
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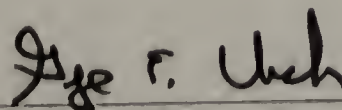
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ABSTRACT

REFERRAL, PERSISTENCE IN THERAPY AND DROP-OUT PATTERNS
OF ELDERLY CLIENTS IN A COMMUNITY MENTAL HEALTH CENTER

May, 1988

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The subjects of this exploratory study were 298 elderly clients who were treated between 1980 and 1986 by a community mental health center program which offered psychotherapy to elders. Data were collected from the clients' case records on sources of referrals for treatment, reasons for referrals, clients' diagnoses, complaints made by clients during therapy, background and demographic information on clients, number of therapy sessions clients attended, and reasons therapy terminated.

The data were then analyzed in order to discover statistically significant patterns and to test twelve hypotheses concerning sources of referrals, reasons for referrals, diagnoses, and persistence in therapy.

The results indicated that more referrals were made by social service workers than by physicians or relatives. A relatively large number of community residents were self-referred. Both community residents and residents of institutions, such as nursing homes, were

more often referred for emotional problems than for management difficulties, but management difficulties were a more common reason for the referral of residents of institutions. Depression was a factor in many referrals.

The most frequent diagnoses were adjustment, organic brain and affective disorders. Organic brain disorders, schizophrenia and paranoid disorders were more common among residents of institutions than among community residents. There was no significant difference between residents of institutions and community residents in the incidence of affective, adjustment and anxiety disorders.

Women complained more frequently than men about social isolation and loneliness. There was no significant difference between residents of institutions and community residents in respect to complaints made during therapy.

Clients with most disorders terminated their own treatment, but those with organic brain and psychotic disorders usually had their treatment terminated by their therapist.

Low drop-out rates were associated with clients with disorders which caused severe discomfort (e.g. affective, somatoform and organic brain disorders), who were religious, who were socially inactive, who lived in institutions and who were in crisis. Drop-out rates were not significantly related to self-referral, symptoms of paranoid ideation or depression, support from relatives, age, gender or whether treatment was in a clinic or in the client's home.

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C H A P T E R I

INTRODUCTION

This report is about an exploratory study on patterns of referral, persistence in therapy and drop-out from treatment by clients in a community mental health center program offering a full range of psychological services to the elderly. Although the elderly are a large and growing segment of our population, very little research has been done on these topics. There are currently very few scientific articles concerning the referral of elders for mental health services and none about their persistence in therapy or dropping out of treatment.

The subjects in this study were clients in a program established by a community mental health center to provide a wide range of mental health services to elderly people. The research involved the collection of data on such variables as who refers a client for mental health services, the reasons given for the referral, the complaint(s) made by the client while in therapy, the diagnosis assigned by the therapist, the number of therapy sessions attended by the client, whether the termination of therapy was initiated by the client or the therapist, the reason for the termination and a wide variety of personal characteristics of the client, such as age, marital status, level of formal education and living arrangements. These variables were then examined for correlations which indicated statistically significant patterns and several hypotheses are tested against the data.

The few previous studies on the patterns of referral of the elderly

for community mental health services (e.g. Ruffin and Urquhart, 1980; Knight, Reinhart and Field, 1982) have primarily concerned only such specialized services as crisis intervention or the assessment and/or prevention of institutionalization. In part, this reflected the limited range of services available from most programs established for the elderly by community mental health centers. Almost all such programs have been designed to offer only one or a few specific service(s), such as assessment, service coordination, crisis intervention, or a support group. The program upon which this study is based, on the other hand, offers the full range of psychological services normally available to people of all ages at a community mental health center, even though, in this case, they are provided by a program established specifically to serve elders.

There is absolutely no information in the current scientific literature on the factors associated with elderly people who drop out of therapy. Although it is often assumed that elderly clients who refer themselves into therapy are more likely to continue than those clients who are referred by others, there is currently no empirical evidence to support that contention and it was one of those tested in this study. A wide variety of other hypotheses about the probability that specific types of clients would continue in therapy or would drop out were also put to the test. For example, this study investigated the relationship between persistence in therapy and such variables as the source of the initial referral, the client's marital status, the diagnosis assigned the client, the accessibility to the client of other forms of support

(e.g. relatives) and the client's residential situation. This study also explored whether the factors which have already been identified as barriers which tend to discourage elders from entering therapy in the first place (Gaitz, 1974; Knight, 1978-79; Levy, 1981; Waxman, Carner and Klein, 1984) are also related to clients dropping out of therapy.

The implications of this research for clinicians and for those planning services for the elderly could be substantial. For example, it would be valuable for a therapist or diagnostician to know at the time of intake that particular clients are at considerable risk of dropping out, that particular clients are likely to be neglected, and that clients referred by certain sources are likely to require special attention.

In the following chapters the current scientific literature relevant to this research is described and assessed, the hypotheses tested in this study are presented and explained, the research methods are described and explained, the results of the research are presented and discussed, and, finally, conclusions are drawn and implications are made for both future research and clinical application.

CHAPTER II

REVIEW OF THE LITERATURE

Mental Illness in Later Life

The Frequency of Mental Disorders Among the Elderly.

No valid or reliable studies. We do not know how common mental illness is among the elderly. According to Redick and Taube (1980), there have been no valid or reliable studies or surveys which can be used as bases for estimating the prevalence of mental disorders among elders. In part this situation can be attributed to the fact that the elderly generally do not utilize mental health services as frequently as younger people, consequently service utilization rates may not accurately portray the actual prevalence or even the full range of disorders which exist among this population. As Christenson and Blazer (1984) have noted, surveys suggest that numerous elderly individuals residing in the community experience psychotic-like symptoms, but receive no treatment and go unrecorded. According to a survey conducted in 1975 by Redick and Taube (1980), the elderly constituted only 5% of the admissions to psychiatric services (ie. inpatient services at state and county mental hospitals, private psychiatric hospitals, general hospital psychiatric units, and outpatient services at community mental health centers and both private and general hospitals). Rosen and Rosen (1982) said that the elderly are only 2% of the private psychiatric patients. Since elders are over 12.5% of the total population (United

States Senate Special Committee on Aging, 1986), this means that they are utilizing mental health services at only a fraction of the rate of the general population.

Considering the fact that some of the stresses which trigger or contribute to some mental disorders may actually increase and accumulate with increasing old age (Gianturco and Busse, 1978), it seems probable that a large percentage of the elderly mentally ill are receiving no services and are not recorded. Evidence of this can be found in a study conducted by Brody and Kleban (1983) in which they asked elderly people whether they had reported to anyone the physical and mental health symptoms they had experienced in the previous month. They found that although a slight majority discussed their symptoms with someone (e.g. family, friends, health professionals), a large percentage of the symptoms went completely unreported. A similar finding was made by Abrahams and Patterson (1978-79). When they asked very depressed elderly subjects what they did to alleviate their depression, there was not a single mention of seeking psychiatric help. About 12% had seen their physician, who usually prescribed tranquilizers; another 10% had talked to friends or relatives; but the majority said they did nothing about the situation. Almost half (46%) of those who had experienced lengthy periods of emotional disturbance and inability to function had received no medical or psychiatric help and nobody had visited the local mental health center.

Another indication of the limited amount of professional help provided to elders with serious mental disorders is the fact that only

25% of the individuals with a dementing illness reside in long-term care facilities; the remaining 75% reside at home (Kay and Bergmann, 1980). The factor which differentiates between the demented elderly who live in residential facilities and those living in the community is not, as one might expect, the degree to which the persons manifest psychotic symptoms or problem behaviors associated with cognitive impairment, but the availability of support services in the community, particularly by family members. Consequently, it is difficult to determine the actual prevalence rate of mental illness, particularly when organic brain syndromes are included.

The measurement of service utilization is considerably complicated by the fact that the admission rate to state and county mental hospital inpatient services has declined significantly since the early 1970s due to the shift away from the housing of the chronic mentally ill elderly in long-term care psychiatric hospitals toward their placement in nursing homes, which Shadish and Bootzin (1984) have characterized as "transinstitutionalization". Prior to this shift, Butler (1974) estimated that the elderly accounted for 25% of the annual admissions to state mental hospitals and Kramer, Taube and Redick (1973) demonstrated that data collected in 1968-69 indicated that 30% of the population of mental hospitals were 65 or older. By 1973 the elderly constituted only 5.3% of the admissions to mental hospitals (Redick and Taube, 1980). From 1969 to 1973 there was a 38% drop in the number of elderly residents in long-term care psychiatric hospitals and a 50% increase in the admission to nursing homes of elderly persons with chronic brain

disorders (Redick and Taube, 1980). Eisdorfer (1977) estimated that by the late 1970s twenty-five percent of the more than one million patients in nursing homes were primarily psychiatric patients. A 1973-1974 survey cited by Redick and Taube (1980) found that 6% of all nursing home residents over the age of 64 had previously been in some form of psychiatric facility. While admissions to state and county mental hospitals have declined, the admission rates to private and general hospital inpatient psychiatric services have increased considerably. However, the elderly have never exceeded 10-12% of the admissions to any inpatient services or 4-5% of those being treated by mental health centers and receiving outpatient services.

Although service utilization rates are of questionable validity as an assessment of the prevalence of mental illness among the elderly, they do at least provide some insights into some of the more severe disorders which have resulted in treatment. What follows is a synopsis of what is currently known about mental illness and mental health service utilization among elders. Since some of the research which will be cited was conducted when the DSM II terminology was used, some of the data are in those terms, although the DSM III are used here whenever possible.

Predominance of a few disorders. While older people have manifested all of the psychiatric disorders observed in younger populations, the majority of disturbances among elders tend to fall into a relatively small number of categories, specifically organic brain disorders, schizophrenia (particularly paranoid reactions), affective disorders,

hypochochriacal states, transient situational disturbances, acute and chronic anxiety states and alcoholism (Pfeiffer and Busse, 1973).

Psychotic disorders. Pasamanick (1962) found the rate of psychosis among the elderly to be 4%. This rather high percentage was based upon data collected from clinical and laboratory evaluations of 809 respondents in a stratified sample at Johns Hopkins Hospital, three state mental institutions and a Veterans Administration hospital. It probably reflects a high rate of admission of older people with organic brain disorders and persons with functional psychoses who have grown old in hospitals. As a result of transinstitutionalization most patients such as these have been transferred to nursing homes. Unfortunately, Pasamanick did not describe what criteria were used to classify a person as psychotic, nor did he list the different forms of psychoses.

Organic brain disorders. According to Kay and Bergmann (1980), the rate of organic brain disorders among people of age 60 or older is generally accepted to be between five and eight percent. For those over 80, the rate approaches 20%. Kay and Bergmann (1980) found an organic brain disorder rate of 6.3% among people over the age of 65. Organic brain disorders, particularly dementia associated with Alzheimer's disease and multi-infarct syndrome, is responsible for nearly half of the admissions of elderly people to state and county mental hospitals, a pattern which has not changed with transinstitutionalization (Redick and Taube, 1980). Organic brain disorders have also been the reason for 28.9% of the admissions of elders to the inpatient units of general hospitals, 25.1% of their admissions to inpatient services at private

hospitals and 23.8% of the outpatient services by these same hospitals. As was noted earlier, only 25% of the individuals with a dementing illness reside in hospitals and nursing homes; the remaining 75% reside at home, not because their symptoms are less pronounced, but usually because relatives are willing to provide care for them at home (Kay and Bergmann, 1980).

Schizophrenia. In their review of the literature, Kay and Bergmann (1980) found that the prevalence rate of active cases of schizophrenia and related psychoses after the age of 60 was between .003 and .005 percent. That finding clearly conflicts with Pasaminick's (1962) earlier discovery of a 4% rate of psychosis among elderly subjects. It is highly probable that the discrepancy can be attributed to the fact that Pasamanick included in his subject population persons who had organic brain disorders with psychotic symptoms and those who had been diagnosed as psychotic at an earlier age, but who were symptom free at the time of the study.

Prior to the 1950s there was a reluctance by clinicians to diagnose schizophrenia in persons over the age of 40 or 50. When symptoms were observed for the first time in older persons, they were usually attributed to cerebral organic factors. As Post (1980) has pointed out, pioneering work by Bleuler (1943) and Lechler (1950) demonstrated that late-onset schizophrenia did occur without accompanying organic brain disorder. A review of case register data by Adelson, Dawnham, Stein and Susser (1968) demonstrated that new referrals were still being made for individuals over the age of 70. However, Post (1980) suggests that late

onset schizophrenia tends to occur in persons who have displayed abnormal behavior or adjustment difficulties throughout their lives. Some evidence suggests that certain types of stresses, in addition to factors in the individual's makeup, may play a role in triggering onset of the disorder. Dementing illnesses, which are more common among the elderly, were seen by Post (1980) as precipitating paranoid, schizophrenia-like or paranoid-schizophrenic symptoms. Late-onset schizophrenia is also more frequently observed among people with low socio-economic status, who are unmarried, who live in isolation and who have few surviving relatives (Post, 1980). Cooper, Garside and Kay (1976) have also demonstrated a connection between late-onset paranoid symptoms and deafness. Their study indicated that elderly depressed subjects were more likely to experience age-related hearing impairments, while elderly paranoid subjects tended to have hearing losses attributable to ear diseases and deafness starting at an earlier age. The authors postulated that in the latter case deafness over a long developmental period influenced the individual's thinking.

According to Post (1980) late-onset schizophrenia is milder than that which occurs in younger adults and there is a decrease in symptoms in people with long-standing forms of schizophrenia as they grow older. The psychoses seem to center around the themes of personal possessions and sexuality, and they are expressed in very concrete terms. While paranoid ideation is fairly common, the production of elaborate delusional systems is very rare. Paranoid delusions tend to be observed in both schizophrenia and affective psychoses in later life, and the

rate of such delusions appears to be relatively high among the elderly. When Christenson and Blazer (1984) examined the responses of respondents of age 65 and older who were part of a stratified, random sample drawn for the Older American Resources and Services (OARS)-Durham survey in early 1972, they found that 4% of the community-resident elderly exhibited persecutory ideation. Unfortunately, limitations in the structure of the survey did not permit analysis of the frequency of specific psychological disorders. Post (1966) concluded that in England 10% of all patients admitted to psychiatric hospitals in old age display paranoid forms of psychoses in which there was no gross organic brain disorder.

The relationship between paranoid symptoms in later life and schizophrenia in the classic form is not clear. In Post's study, only about a third of the 93 patients with paranoid symptoms displayed classic symptoms of schizophrenia with the characteristic disorganized thought process, symbolization and delusion formation. Another third displayed only paranoid auditory hallucinations with no other symptoms of schizophrenia, and the last third exhibited paranoid delusions which were concrete and almost understandable, given the patients adverse living conditions and/or social and partial sensory isolation due to deafness.

Affective disorders. Unlike schizophrenic symptoms, bipolar affective disorder which recurs in later life does not become less severe and disruptive with increasing age (Gianturco and Busse, 1978). Manic attacks tend to become more frequent and are characterized by less

overt behavior. Affect takes on a surly, more disgruntled quality, rather than the elation experienced at an earlier age. In addition, verbal statements have a more persecutory content to them (Post, 1978). Depressive psychoses outnumber bipolar disorders in later life. In a study of 220 patients hospitalized for affective disorders, only 13% had manic symptoms (Roth, 1955). Both forms of depression (ie. both depressive neuroses and affective psychoses, such as unipolar disorder) are relatively common among the elderly. Between 40% and 50% of the admissions to private and general hospital inpatient psychiatric services and outpatient psychiatric services are for one of these varieties of depression (Redick and Taube, 1980). Endogenous/unipolar depression, which belongs at the more severe affective psychoses end of the continuum, is characterized in old age by retardation in functioning, guilt, self-deprecation and hypochondriacal ideas or somatic delusions. The depression is worst in the morning and sleep is interrupted by early morning awakening (Epstein, 1976).

Although it is widely assumed that depression is aggravated with increasing age, Ciompi and Lai's work (1969) indicates that there is some variability from person to person. The subjects of their research were depressed patients who had been admitted to a university hospital in France prior to old age (mean age = 53) and who were alive and over the age of 65 (mean age = 73.5) at the time of the study. One third of the subjects had not experienced a depressive episode after the age of 65, another third experienced shorter and milder attacks and the remaining third had depressive symptoms as severe as, or more severe

than, those they had experienced at an earlier age.

Anxiety disorders. It is not common for classic forms of neuroses (e.g. phobic reactions, anxiety reactions, obsessive compulsive neuroses) to arise for the first time in later life. Elderly persons who do not exhibit neurotic-like disturbances tend to show depression of varying degrees, with the predominant symptoms being feelings of loneliness and rejection, anxiety, somatic complaints, hypochondriacal fears, irritability, attention-seeking, and withdrawal (Simon, 1980).

Depression. The prevalence of depression among elders is open to question. Estimates of its frequency range from 5% (Blumenthal, 1975) to about 50% (Leighton, Harding and Macklin, 1963). Much of this discrepancy lies in the failure to employ a uniform definition of depression or a standardized means by which to assess it. There is less variation in the reported frequency rates for major affective disorders, which have ranged from 1% to 3%. For example, when Blazer and Williams (1980) used the OARS Depressive Scale to evaluate 997 noninstitutionalized elders, they found a 14.7% prevalence rate of depression, however, only 1.8% met the criteria of primary depressive disorders and only 1.9% could be classified as secondary depressive disorders as defined in DSM III. Blazer and Williams attribute much of the depression among the elderly to decreased life-satisfaction and periodic episodes of grief secondary to the physical, social and economic difficulties encountered by the aged.

Neurotic depressions among the elderly are characterized by a milder form of emotional disturbance than is evident among younger depressed

persons. Diurnal variations are not usually seen. While sleep is undisturbed in some, insomnia is a problem for others (Epstein, 1976).

Neurotic depressions tend to be more reactive in nature and the elderly are usually seen as particularly vulnerable to such disorders because increased age is associated with numerous losses. While some investigators (e.g. Gianturco and Busse, 1978) have attributed depressive reactions to stresses stemming from encountered losses, others (e.g. Post, 1978) have attributed depressive reactions to a complex relationship among a set of predisposing factors in which physical health, stress, premorbid personality and adjustment patterns all play important roles. Bergmann (1978) has raised the interesting point that one of the difficulties which clinicians have in perceiving acute neurotic illness in older persons who have a history of maladjustment in earlier life is that the precipitating causes are so "adequate" and understandable (e.g. bereavements, real health problems, financial difficulties), thus the causes of neurotic disorders in later life have received less systematic exploration than the causes of similar disorders among younger people.

Hypochondriasis. Hypochondriasis has been considered a separate neurotic disorder by some (e.g. Pfeiffer and Busse, 1973), but that view has been challenged by a number of investigators (e.g. de Alarcon, 1964; Kay and Bergmann, 1966; Bergmann, 1971) who perceive it as a symptom of masked depression. Ciompi and Lai (1969) have described a progression in late-life depression from an "ideo-affective level", in which the person experiences guilt from self-blame, to a more "somatic level", in

which hypochondriacal complaints and fatigue predominate. In fact, somatic illness and/or fatigue is characteristic of the most frequent type of depression observed in old age (Stenback, 1980). Another reason for classifying hypochondriasis as a symptom of depression is de Alarcon's (1964) finding that hypochondriac delusions are strongly linked with attempted suicide in aged depressed patients.

The prevalence rate of hypochondriacal symptoms among the elderly is somewhat open to question. A pioneering study conducted by Busse (1970) indicated a 33% rate of hypochondriasis among elderly persons residing in the community who volunteered for a medically-based research project. On the other hand, a study conducted by Stenback, Kumpulainen and Vauhkonen (1979, see also Stenback, 1980), involving a stricter definition of hypochondria and a random sample of community residents drawn from birth registers, suggested that the actual rate is closer to 4%. As Stenback (1980) noted, elderly hypochondriacs would be extremely likely to volunteer for a study related to medicine.

Milder psychiatric conditions. While the rates of psychoses rise with age (presumably due to organic brain disorder) the number of cases of neuroses among the elderly does not differ substantially from that of other adults (Passamanick, 1962). Although neurotic disorders do not increase with age, they do not decline either. This finding has been based upon studies of general practice and utilization rates of various psychiatric services (Passamanick, 1962). Bergmann (1978) postulates that psychiatric disorders which come to light, do so through their "nuisance value" and that some forms of neurotic disorder in old age

fail to reach such a critical level. Some examples of this would be disorders involving acute and chronic anxiety states and transient situational disturbances. A thorough search of the literature revealed little about these conditions other than brief mention of their names in passing. Simon (1980) described anxiety reactions in very general terms which might apply to any age level, with no specific mention of any specialized observations of aged clients, except for a few with phobic anxiety. Simon (1980) also recorded phobic reactions in old age in both chronic and acute states. Acute attacks tend to be dramatic and Simon saw them as a response to severe physical illness and surgery. Transient, situational disorders, which could presumably include phobic anxiety, have been found by Redick and Taube (1980) to comprise 11.4% of elderly admissions to outpatient psychiatric services although they did not find this diagnostic classification significantly represented in any of the inpatient services.

Alcoholism. Most rates of alcoholism among the elderly have been computed on the basis of admissions to psychiatric hospitals and outpatient clinics. Studies of this type (e.g. Cahalan, 1970; Knupfer and Room, 1964) report a decline in alcoholism with increasing age. Despite that trend, the number of elderly alcoholics is significant. Gaitz and Baer (1971) estimated that as many as 10% of those age 60 and over are heavy drinkers. Alcoholism appears to be a factor among elderly people experiencing mental health problems. One study of a community health center found that 17% of the clients aged 65 and older showed evidence of alcohol abuse (Zimberg, 1974).

Although the supportive data has not yet been gathered, Simon (1980) believes that late-onset alcoholism is a reaction to age-related stresses and physical illness or is a side effect of depression. Simon also says that once help is given to alleviate these conditions, the need for alcohol declines. The effects of advanced alcoholism are social isolation, falls, malnutrition, general physical deterioration, and dementia (Simon, 1980).

Suicide. Suicide tends to occur in the elderly at a rate higher than for any other age group. Although there has been a significant decline in the rate of suicide by the elderly in the last 40 years, 25% of all suicides are committed by the aged (Butler, 1974). The decline in the rate of suicide has been linked by Marshall (1978) to improved economic conditions and by McIntosh (1985) to the increasing proportion of women in the elderly population, since women are less likely than men to commit suicide at any age. Other categories of elders who are more likely than others to take their own life include the widowed, those who have experienced recent losses, those with physical illnesses and intractable pain and those who have undergone status changes (e.g. loss of income, roles, independence). For people experiencing depression, death is a contemplated solution. A community survey of elderly volunteers by Busse (1961) revealed that more frequent and more annoying depressive periods were experienced in later life than in earlier adulthood. The respondents reported feeling discouraged, worried or disgusted with their sense of uselessness to such a degree that they felt no reason to continue to live. Although only a few subjects

admitted thoughts of suicide during a depressive period, a larger percentage stated that they would welcome death if it were painless. The elderly are less apt to make unsuccessful suicide attempts than younger people. While contemplating suicide they often drop numerous clues as to their intention, including verbal statements which suggest a desire to die, giving away prized possessions, sudden changes in behavior, and signs characteristic of depression (e.g. sleep and eating disturbances, lessened energy, feelings of hopelessness and helplessness, guilt, low self-esteem, withdrawal, and apathy) (McIntosh, 1985).

Young-old versus old-old. When Redick and Taube (1980) studied elders receiving inpatient and outpatient psychiatric services they discovered that, in general, admission rates tend to be higher for the young-old (ages 65-74) than for the old-old (ages 75 and older). Two exceptions to this pattern were that admissions to general hospital psychiatric inpatient units were slightly higher for males over the age of 75 than for males between 65 and 74 and admissions to outpatient psychiatric services were higher for females over the age of 75 than for females between 65 and 74 or for males.

Need for Community Mental Health services for Elders

All this evidence seems to indicate that although the elderly are a large and growing portion of our population, they are less likely to receive psychiatric services than the general adult population despite the fact that they incur a considerable number of psychiatric problems. These problems most frequently include organic brain disorders,

persecutory ideation, depression, hypochondriasis, alcoholism, and a high rate of suicide. This suggests that community health services should be directed toward the elderly.

Factors Correlated with Mental Illness

There have been numerous studies of the factors which correlate with mental illness among the population in general and among elders in particular. The factors which have received the greatest attention have been gender, physical health, marital status and family relationships, socio-economic status, social relationships, education, race, and personality characteristics. A brief review of the findings concerning most of these topics as they relate to this study will follow. The considerable quantity of scientific literature on personality characteristics will not be reviewed here because personality factors are not part of the present study.

Because a large proportion of the research has been framed in terms of stress, it is appropriate to begin with a review of that literature. Thereafter, the methods and some of the findings of several major multifactorial studies will be presented so that the subsequent review of specific discoveries concerning particular factors may be seen in context.

Stress

The relationship between stress and increasing age has been studied extensively because many investigators (e.g. Gianturco and Busse, 1978;

Renner and Birren, 1980) believe that stress inducing factors may be related to mental illness and that the elderly are particularly susceptible to stress.

There is no universally accepted definition of stress. Part of the difficulty lies with the variety of models which have been proposed to explain stress. In his review of the literature on this topic, Moss (1973) categorized the more accepted models into three groups. Those in the first category view stress as a physiological response to physical, chemical and organic agents. This approach is based upon Selye's General Adaptation Syndrome model, which involves a specific pattern of response to a variety of stimuli. The second category contains models in which stress is perceived as a physiological response to social and psychological stimuli. Focusing on the interaction between the individual and the external environment, these models emphasize that the individual's response depends upon his/her past experiences, life situation and defense mechanisms. The models in the third category view stress as a behavioral response to social and psychological stimuli. These models emphasize the individual's feeling that he/she is unable to meet the demands of a situation (Eisdorfer and Wilke, 1977).

Although individuals vary somewhat in their perception of what is stressful (Eisdorfer and Wilke, 1977), there has been a general agreement among investigators as to the types of social/psychological stimuli which most individuals perceive as stressful. These social/psychological stimuli are frequently included in a life-events scale, which is one method used to examine the level of stress people

are experiencing. This consists of a list of specific events (e.g. minor traffic violation, death of a spouse) which the respondents weigh individually for the frequency with which they occur and/or the amount of stress they elicit. The scale developed by Holmes and Rahe (1967) was one of the first and it is still one of the most widely used. It contains a list of 42 items which include a range of events commonly experienced by adults. Numerous researchers (e.g. Amster and Krauss, 1974; Hultsch and Plemons, 1979; and Chiriboga and Cutler, 1980) have criticized the limited scope of the Holmes-Rahe scale, particularly as it applies to the elderly. In an effort to resolve this difficulty, Amster and Krauss (1974) developed a scale which they felt was more appropriate for elders. Their scale included such events as institutionalization, failing eyesight, hearing losses, painful arthritis, feeling of slowing down, loss of driver's license, reaching 65, and reaching 70.

Sands and Parker (1979-80) used both the Holmes-Rahe scale and the Amster-Krauss scale in a cross-sectional study in which subjects in three age groups (18-24, 30-40 and 65-86) were questioned to determine whether specific events could be more stressful or less stressful at different points along the life cycle. Relatively few items resulted in different responses by the three age groups. In general, the Amster-Krauss events were viewed by younger subjects to be as stressful as they were to elderly subjects. There were, however, some differences in the responses to individual items. For example, there were significant differences in the responses to "changes in social

activities", "feeling of slowing down", "vacations" and "holidays and anniversaries", with the elderly reporting these as more stressful than younger adults. On the other hand, the elderly reported considerably less stress than younger subjects for death-related events (e.g. death of a spouse, close friend or close family member). Elderly subjects also rated "changing to a different line of work" as less stressful.

While Sands and Parker's work indicates that the elderly are not significantly different from the general population in their perception of life-event stresses, some investigators (e.g. Gianturco and Busse, 1978) feel that the accumulation of stresses has a deleterious effect on the psychological well-being of the elderly. Consequently, some research has been done on the psychological effects of accumulation of stress over time. For example, Chiriboga (1982) conducted a five year, longitudinal study on 52 high school seniors, 50 newlyweds, 54 middle aged parents and 60 persons who were facing retirement when the research commenced. Although he did not give the age of the subjects in this last category, it is reasonable to assume that most of them were over 65, at least by the conclusion of the research. Three times during the five years, a battery of tests, including a 138 item life events inventory, a second instrument describing 12 emotional states and a third instrument with a 42 item inventory of psychological symptoms were administered to all subjects. Although some of Chiriboga's findings could be attributed to cohort differences, at least two general developmental trends could be discerned within all cohorts over the five year period. Women were found to be more affected by the accumulation

and diminution of stress than men. This will be discussed in greater detail in the section devoted to gender. The second major trend made evident by Chiriboga's work (1982) was that the emotional status of the subjects prior to their exposure to stress may influence their reaction to the stress. For example, women who manifested high stress were less satisfied, higher in negative affect and more symptomatic than other women, even before the impact of stresses. This confirms the hypotheses proposed by several researchers (Costa and McCrea, 1978; Chiriboga and Cutler, 1980; Pearlin, 1980) that personal characteristics of some people may predispose them to an inability to handle stress well.

Chiriboga (1982) also pointed out that the basic life-events approach is limited because it does not take into account the various categories of stresses which occur over the life-span (e.g. anticipation of stress; being off-time; non-events, such as not getting married; chronic stress conditions).

Lazarus and De Longis (1983) have made another criticism of the life-events approach to measuring stress. They argue that life-events are a more peripheral source of stress, since such events are not usually the persistent or even transient every day type pressures people encounter. Although life-events are in many cases causally related to daily pressures, there are many every day problems that have little to do with life-events (e.g. misplacing or loosing things, not enough time for family, filling out forms, planning meals, concern about weight, and unchallenging work). Lazarus and De Longis recommend the use of a supplementary scale designed to measure the stress resulting from

on-going daily pressures, and they have developed a Hassles Scale based upon a 117 item questionnaire listing potential problems encountered in daily life. While the Hassles Scale has been found to effectively predict adaptational responses (e.g. morale, psychological symptoms, somatic illness), the term "hassle" does not clearly indicate which event are stress-inducing.

A potentially more effective approach is the 35 item Worry Scale developed by Wisocki and Handen (1983) to assess the uncontrollable negative cognitive activity associated with anxiety in elderly people. The scale has been administered (Wisocki, Handen and Morse, 1986) to 54 community-active elderly who attended a senior center and 44 homebound elderly who did not leave their homes more than once a week, except for medical reasons. Although both groups reported relatively few worries on the three subscales (finances, health, and social conditions), some general patterns emerged. Women in both groups reported more concerns in each worry category than did men. Age was inversely related to total worry scores in the homebound group, but not among the community-active subjects. In both groups health-related items were of greatest concern, while social conditions were of the least concern.

Multifactorial studies. While most early investigations focused on one or two types of stressors or factors related to mental illness, some researchers realized that it was unlikely that psychological maladjustment could be attributed to a single factor. One of the earliest attempts to discover the relationship between mental health and a variety of factors was Bellin and Hardt's (1958) survey of 1,803

elders residing in an urban community. The survey revealed that mental health was positively related to higher socio-economic level, physical health and younger age. A similar finding appears in Bergmann's (1970) assessment of the distribution of neurotic symptoms among British elderly residing in the community. The subjects of that study, ranging in age from 65 to 80 years, were chosen by means of a random sample. They represented a wide range of socio-economic conditions and showed no evidence of gross psychological psychoses. Subjects who developed neurotic symptoms after the age of 60 were found to differ statistically from other subjects in three ways: they had experienced more physical illnesses, they were more likely to be female and they were more likely to have certain personality traits (e.g. were anxiety-prone). Physical illness proved to be, by far, the greatest discriminator.

The most comprehensive study of this type was undertaken by Harel, Sollod and Bognar (1982), who examined four factors for their relevance to mental health among adults of all ages. These factors included health and functional status, socio-economic status, social integration, and demographic characteristics. Health and functional status were determined by the subjects' own ratings of their health and limitations, participation in activities, performance of daily routines and level of assistance with daily routines. Socio-economic status was determined by monthly income, the subjects' own perception of the adequacy of their income and the interviewer's rating of economic resources. Social integration was determined by the subjects' own perception of the number and frequency of social interactions, having someone to depend on,

feelings of loneliness, as well as the interviewer's rating of social resources. Demographic characteristics were defined as sex, race, age, education, marital status and living situation. The assessment of mental health was based upon a combination of an interviewer's rating, a self-rating of mental and emotional health and a 15 item inventory taken from the MMPI. Five items of the 15 item inventory were drawn from the scale on hypochondriasis, five from the scale on depression, and five from other scales (e.g. hysteria, paranoia and schizophrenia). These last five were ultimately reduced to one variable called psychopathology.

Correlation analysis indicated a significant positive relationship between mental health and three of the four factors: better physical health, higher socio-economic level and adequate social resources. Among the demographic factors, only more education and being married were found to have any positive relationship with mental health. Multiple regression analysis indicated that physical health was most closely related to mental health. Socio-economic resources and social resources ranked as second and third factors respectively.

A more recent multifactorial study on a random sample of urban, community-residing elderly conducted by Haug, Belgrave and Gratton (1984) has re-confirmed the high correlation between mental health and physical health.

An exception to this pattern was found by Warheit, Holzer and Schwab (1973) who collected data concerning race, sex, age and socio-economic status from a random sample of adults residing in the Southeast. By

multiregression analysis they discovered that mental health was significantly related to only two variables: high socio-economic level and being female.

Physical health. It is not surprising that so many researchers have found a high correlation between poor physical health and mental illness among elders. There can be no doubt that physical disabilities and poor physical health are major stressors for the elderly. A national Health Survey conducted in 1969-1970 (Kart, Metress and Metress, 1978) found that 42% of those over the age of 64 had some "activity limitation" resulting from health problems, while only 11.7% of those under age 65 reported such limitations. Thirty-seven percent of the elderly population sampled had limitations which prevented them from carrying out major activities, while only 9.1% of those under age 65 had such difficulties. Raymond, Michals and Steer (1980) found that interference in carrying out daily living functions, particularly when people are restricted to home, was stressful.

Preston and Mansfield (1984) tested 200 rural elderly on both their perception of stress associated with physical changes that had occurred to them in the past year and their ability to use the helping networks available to them to cope with the stress. The participants in their sample reported considerable stress associated with physical illness. In fact, the single stress most frequently reported by subjects in the mentally healthy group were changes in their health or that of members of their families. Subjects in the poorest health, including those who were capable of only limited activity, reported the greatest stress.

Preston and Mansfield attributed the effect of poor health to a decrease in coping mechanisms, a decreased sense of control over one's life and, possibly, inadequate social support. However, their sample of individuals with both high stress and poor health consisted entirely of women, the majority of whom were widowed and living alone. An alternative explanation might be the lack of emotional support and/or financial limitations, both of which are strongly correlated with widowhood (Ross, 1974; Levy, 1981). Unfortunately such an analysis is not possible because Preston and Mansfield made no mention of socio-economic level in their report.

Blazer and Williams (1980), who investigated the rate of depressive symptoms among community residing elderly, reported that 44% of the depressed subjects in their study had impairments in health. Unfortunately they did not make this statistic more meaningful by comparing it to the rate of impairment among non-depressed subjects.

As mentioned previously, the multifactorial studies by Harel, Sollod and Bogнар (1982) and Haug, Belgrave and Gratton (1984) found physical health to be the most significant correlate of mental health. Bergmann's (1970) study of subjects who developed neurotic symptoms after the age of 60 also found poor physical health to be the most significant of the three variables for which he found some correlation.

The important distinction between actual physical health and the subjective perception of it should also be noted. As one would expect the old-old (aged 75 and older) tend to have more health problems than the young-old (Shanas and Maddox, 1976). However, even though more

health problems are likely to occur with increasing age, the proportion of elders who report that their health is good does not decline as age increases (Shanas, Townsend, Wedderburn, Friis, Milhoj and Stehouwer, 1968). In fact Ferraro (1980) found that old-old subjects who, as a group, reported more health related problems than young-old subjects, tended to be more positive in rating their own health problems. Ferraro attributed this finding to the tendency of people to evaluate their own condition relative to that of their peers. Older women in particular reported better health than men, despite the fact that they suffered more disabilities, a finding which confirmed earlier reports by Maddox (1962) and Fillenbaum (1979).

Socio-economic status. Many researchers have discovered a high correlation between mental health and socio-economic level among adults of all ages. For example in reviewing 34 studies, Fried (1969) found that 29 of them reported significantly higher rates of psychoses among subjects in lower socio-economic strata. When Warheit, Holzer and Schwab (1973) applied multiple regression analysis to data concerning race, sex, age and socio-economic status collected in a random sample of adults residing in the Southeast, they discovered that mental health was significantly related to only two variables: socio-economic level and gender, although they did not control for physical illness. Bellin and Hardt's (1958) multifactorial survey also revealed that socio-economic level was a critical risk factor.

The most popular explanation for this strong relationship between socio-economic factors and mental health is that lower status is

frequently related to inadequate diet, poor housing, and limited access to both medical care and community resources, all of which increase the rate of mental breakdown (Lowenthal and Berkman, 1967; Srole, Langer and Michael, 1962).

It may be that the distinction between objective reality and subjective perception of health discovered by Ferraro (1980) is paralleled by an objective/subjective dicotomy relative to economic condition. Harel, Sollod and Bognar's (1982) analysis indicated that socio-economic factors were the second most significant correlates of mental health, ranking immediately after physical health and before social resources. Within the socio-economic category, such subjective factors as the subject's own perception of having adequate financial resources, having enough money for needs, having enough money for extras, and having no need of financial assistance were found to be more important determinants of mental health than such objective measures of financial resources as monthly income or socio-economic status. In a community survey of 704 people over the age of 59, Usui, Keil and Durig (1985) asked the respondents to compare their financial situation to the relative, friend and neighbor to whom they felt closest. Those who rated themselves as comparatively well-off financially, reported higher life-satisfaction, the latter being measured on a scale developed by Neugarten, Havighurst and Tobin (1961). Multiple regression analysis indicated that this perception was more highly associated with life-satisfaction than such objective factors as functional health, age, sex, race, marital status, education, income, household size and social

participation. It would appear that how people interpret or perceive their situation is more important to psychological well-being than the situation itself.

Social relationships. Harel, Solloed and Bogнар (1982) found social integration to be related to mental illness, but less so than either physical health or socio-economic factors. Within that general category, the analysis indicated that mental health was most significantly related to having social resources, not feeling lonely, having someone to depend on, and spending time with others. These patterns among the general adult population also occur among the elderly. Positive relationships between levels of social interaction and personal adjustment have been discovered by most investigators (e.g. Maddox, 1963; Rosow, 1967; Bultema and Oyler, 1971; Graney, 1975; Mulligan and Bennett, 1977-78), although a few studies (Lemon, Bengtson and Peterson, 1972; Smith and Lipman, 1972; Edwards and Klemmack, 1973) have indicated that social interaction is unrelated to adjustment. Conner, Powers and Bultema (1979) have pointed out that qualitative aspects of social involvement tend to outweigh quantitative ones. They also suggested that peoples' own perceptions of the appropriateness of their levels of interaction are more critical than an objective measurement of the interaction itself. Support for this can also be found in Beckman and Houser's work (1982).

Beckman and Houser (1982) demonstrated that among the elderly, perceived adequacy of social involvement was significantly associated with psychological well-being. However, they did not find any

association with two other factors cited by Harel, Sollod and Bogнар (1982): having a confidante and having someone to count on. These findings, however, may have been shaped by Beckman and Houser's sample population of elderly women who had been widowed within the previous six years, as determined by obituaries in newspapers. Only those responding to a mailed questionnaire or willing to be interviewed by telephone were included. All participating widows were asked to nominate a second set of subjects consisting of neighbors between the ages of 60 and 75 who were married and living with their husbands. In both the selection of the widowed subjects and their nomination of others, it is possible that those chosen may not have been truly representative.

Other investigators feel that a confidante is important. Sparacino (1978-79) has pointed out that as people age, a dependable confidante can help them in their efforts to cope with the inevitable physical and personal losses in later life. However, the quantity of such relationships may not be as important as their quality. Lowenthal and Berkman (1967) found that the stresses and losses of aging, such as widowhood, retirement and role loss were much less likely to result in prolonged emotional distress in cases where there was at least one intimate relationship with a confidante.

Elwell and Maltbie-Crannell (1981) have noted the importance of social participation in mediating stress among the elderly, particularly elderly women. Windley and Scheidt (1983) have shown that female elders living alone are less psychologically adjusted than either females living with a spouse or males.

More research is needed on the relationship between mental health of the elderly and the availability of confidantes. As people age, they lose access to organized activities, such as work, which once provided them with some measure of social activity, or at least the potential for social interaction (Burgess, 1960; Streib and Schneider, 1971). These factors and the increasingly transient nature of our communities require older people to rely more heavily on their interpersonal skills to maintain existing relationships and/or to develop new ones.

Gender

A number of studies have pointed out that mental illness in general, and depression in particular, is more frequent among adult females of all ages than it is among adult men. (Lemkau, Tietze and Cooper, 1942; Sorenson and Stomgen, 1961; Taylor and Chave, 1964; and Winokur and Pitts, 1965). Ross (1974) noted that one stress for women is the emphasis placed upon beauty in our society and the perception that aging men remain handsome (i.e. look more distinguished), while women do not. Ross says that in addition to unflattering stereotypes about their appearance, aging women are faced with geographical separation from their children, loss of spouses, poverty, social isolation, and poor access to transportation.

In Chiriboga's (1982) longitudinal study, women were found to be more affected by the accumulation and diminution of stress than men, which was reflected by higher scores on the emotional scale and the number of psychological symptoms reported. Those women who tested as highly stressed in the first and second interviews, but who reduced

their stress by the final interview, showed a modest improvement in psychological well-being. Women who continued to experience a high level of stress showed a steady decline in psychological well-being. Men demonstrated less negative affect and dissatisfaction in response to accumulated stress. Men who reported negative feelings in the first interview, showed a decrease in psychological symptoms in subsequent interviews, regardless of their stress level. Chiriboga attributed this difference between men and women to real differences in the amount of stress experienced by the two genders. His analyses in previous studies (Chiriboga, 1977; Lowenthal and Chiriboga, 1975) have shown that with increasing age, men experience fewer stressful life events than women. These findings that feminine gender is significantly correlated with mental illness is supported by the work of Warheit, Holzer and Schwab (1973) Bergmann (1970), although Bergmann found physical illness was a far more significant correlate.

Education Level

Haug, Belgrave and Gratton (1984) discovered that there was a weak but significant relationship between education and mental health. A similar finding has been reported by Kohn and Schooler (1973) who suggested that this was due to greater ability among the educated to cope with complex and stressful life situations. Harel, Sollod and Bogner (1982) also found education to be significantly related to mental health, but they did not explain how it is related.

Race

Multifactorial studies have shown that race is modestly correlated

with mental health (Hunter and Perry, 1979; Blazer and Williams, 1980; Haug, Belgrave and Gratton, 1984). Blacks have been found to have better mental health than Whites, although the difference has not always reached significance (Warheit, Holzer and Schwab, 1973; Usui, Keil and Durig, 1985).

Marital Status

There have been several studies on the relationship between marital status and mental health among the elderly. A common finding in most of the studies dedicated specifically to marital status (e.g. Locke, Kramer and Pasamanick, 1960; Lowenthal and Berkman, 1967; Palmore, 1973) has been that divorced, separated and never-married elders have higher rates of mental illness than married and widowed people. Generally this finding has been attributed to long-standing adjustment problems which prevented these individuals from developing lasting relationships. As an alternative explanation, Palmore (1973) suggested that non-married elderly people are much less likely than the married to have family support available to them.

The studies concerning the relationship between widowhood and mental illness have had contradictory results. Several studies of elders (e.g. Locke, Kramer and Pasamanick, 1960; Lowenthal and Berkman, 1967) have found that widowed persons have higher rates of mental illness than the married. However, even though the loss of a spouse has been implicated as a stressor by Gallagher, Brekenridge, Thompson and Peterson (1983), the mental health scores of the bereaved are not, on average, within the range of serious psychopathology. Much of the psychological distress

tends to be experienced in the early stages of bereavement. A return to normality and adjustment occurs in most cases (Glick, Weiss and Parkes, 1974). The degree to which a person experiences distress and disorientation following the death of a spouse seems to be partially a function of the extent of the role relationships and interdependency between the spouses (Levy, 1981). Bellin and Hardt (1958) have demonstrated that even though the rate of mental illness was significantly higher among the widowed than among the married, that pattern disappears once physical health, socio-economic status and age are factored out. In other words mental distress appears to result from the physical health and socio-economic conditions often associated with being widowed, rather than from the widowhood itself. Gallagher et al. (1983) noted lack of assistance and support in coping with stressful situations as a factor associated with widowhood, but these may well be outweighed by other factors, such as loss of personal care, changes in living arrangements, and changes in socio-economic status (Bellin and Hardt, 1958; Foner, 1986; Palmore, 1973; and Levy, 1981).

One limitation of most of these studies is a failure to distinguish between bereavement, which usually occurs for a limited period and decreases over time, and widowhood, which usually continues for the rest of one's life. It seems probable that both the stresses and the mental conditions associated with these two conditions are not entirely the same.

A number of researchers have postulated that a spouse supplies a rich source of social interaction and emotional support. Studies on

widows and widowers found that they were significantly more isolated than married people (Bernardo, 1968; Bock and Webber, 1972). Kivett (1979) found that frequent loneliness, as well as poor vision and self-rated poor health, was closely associated with being widowed. He also reported that even when access to transportation was not a problem, elderly widows and widowers reported more episodes of loneliness than the married.

Perhaps the lack of correlation between widowhood and mental health is the result of other people stepping in to fill the role once held by the now deceased spouse. Powers and Bultema (1976) discovered that widows and widowers, lacking the support formerly provided by a spouse, frequently turn to friends to meet their need for intimacy. These widowed elders may have fewer relationships, but they appear to rely more on the ones they do have than do married individuals. As previously mentioned, Scheidt and Windley (1983) found that many widowed elders have a confidante who probably provides the social and emotional support originally obtained from a spouse. Unfortunately, they did not describe who these confidantes were. The proximity of potential social contact also appears to be a factor. For example Rosow (1967) found that reports of loneliness are lower among the widowed who reside in more densely populated housing areas.

Family Support

Although the direct impact of family support on mental health has not received sufficient study, the role of support provided by family members deserves special attention for several reasons. First, family

members provide the form of support which elders find least stressful. Second, in times of stress, elders often turn to their family for support. Third, elders who receive support from their families are much less likely to be institutionalized than those who do not.

One of the most comprehensive studies of family support was conducted by Shanas (1979). She reported findings on two aspects of the family support system: family visiting patterns and family-provided care in times of illness. The data in her report were based upon a 1975 national sample of noninstitutionalized elderly population. The amount of visiting between elders and their children and/or relatives was found to be considerable. Seventy-five percent of those surveyed had seen at least one family member in the week preceeding the interview. Only 10% had not seen one of their children in more than a month. About 21% had no surviving children, and there was some evidence that in these cases siblings and other relatives tended to substitute for children as the providers of social support. More than half of them reported having seen a relative during the previous week. Access to children or some other relative was available to about three-quarters of the aged population. The study of non-institutionalized people over age 59 conducted by Usui, Keil and Durig (1979) indicated that 56% had living children and 24% had living siblings. These findings partly contradict an earlier article by Butler (1978) who reported that 25% of the elderly have no living family and 50% have only distant relatives, such as cousins. Unfortunately, Butler did not explain from what data he obtained his statistics. Part of the discrepancy between these two

reports, may be the result of the inclusion in the study by Usui et al. of people between the ages of 60 and 65 (who would be more likely than older subjects to have living relatives) and the limiting of subjects in that study to community residents.

Several studies have demonstrated that family members are most likely to be the primary caregivers when an elder requires help because of an illness or disability (Bergmann, Foster, Justice and Mathews, 1978; Nardone, 1980; Horowitz, 1985). National health statistics demonstrate that families provide 80% of all home health care for elderly individuals (Brody, Poulshock and Masciocchi, 1978). Shanas (1979) found that during times of illness, spouses were the main source of assistance for most elderly people. Because these spouses were also elderly and were rarely able to manage the full care of an invalid husband or wife, they were often assisted by paid helpers. Children of the disabled elderly, living either in the same household or elsewhere, were found to be the second most frequent caregivers.

A pattern called "substitution" was named by Johnson and Catalano (1981) and subsequently documented in detail in Johnson's (1983) research concerning 167 post-hospitalized elderly people. Rather than sharing the burden of care more or less equally among themselves, family members provided care in proportion to their degree of intimacy with the elder and this in turn tended to determine the quality of care provided. Usually when a spouse was able to provide care, the care was quite comprehensive and the caregiver reported relatively little conflict with the invalid spouse. The result was only modest levels of stress and the

invalid elder was less likely to be institutionalized. When a caregiving spouse was not available, children provided considerable support, but it usually did not equal that given by a spouse. While children said that they were willing to do all they could for their parents, they were more likely than a spouse to report conflict and ambivalence in assuming these duties. When neither spouses nor children were available, other relatives provided some support, but they were even less thorough. More distant relatives, such as nieces and nephews tended to function as overseers of the formal support system and act as intermediaries between the aged and the bureaucracy. The relationship is usually not intimate and the relatives providing care reported interpersonal conflicts, even though their caregiving services were rather limited. Although siblings were likely to have the time to provide care, their own age-related illnesses and their limited intimacy in adult life tended to interfere with their effectiveness as caregivers. Consequently, emotional support was not always extended and the care was apt to resemble that provided by more distant relatives. Even though Johnson's research primarily concerned the attitudes of the caregiving relatives, these attitudes have major implications for the elders receiving care.

Similar studies by Cantor (1983) and Stoller and Earl (1983) found a strong reliance on neighbors and friends when support by family members was not available. These researchers also reported that such informal support was preferable to that provided by formal agencies, even when the same services were provided.

There are also discernable differences in the patterns of care given by daughters and sons. Daughters predominate among adult children who provide direct care (Troll, 1971; Lee, 1980; Brody, 1981; Stoller, 1982; 1983; Cantor, 1983; Johnson, 1983; Stoller and Earl, 1983). Sons tend to play a more active role in decision making and in providing financial assistance (Bahr, 1979; Levav and Minami, 1974; Stoller, 1982, 1983; Treas, 1979). In part this may be due to the fact that women tend to live closer to their families of origin than men and that they are more likely to interact frequently with their relatives (Horowitz, 1985). Troll, Miller and Atchley (1979) found that widowed, elderly women are more likely than elderly widowers to move in with their children when they find it difficult to live alone. And these children are much more likely to be daughters than sons. This may be related to findings that daughters are perceived to be, and perceive themselves to be, emotionally closer to their parents than sons (Adams, 1968; Jackson, 1971; Johnson and Bursk, 1977). In addition, daughters are more likely to have flexible schedules as homemakers than do men in their occupations, although Goodstein (1981) notes that this pattern is changing as the result of trends in the past 20 years (e.g. the shift toward smaller families, an increase in the proportion of women working outside the home and increasing mobility resulting in increased geographical separation of family members).

These trends are apt to have severe ramifications in the future, since family support appears to be the major factor discriminating between elderly people residing in institutions and those residing in

the community. Lawton (1981) reported several findings from a survey conducted by the National Center for Health Statistics in 1977. Only 12% of the residents of institutions were currently married while 54% of those in the community were married. In fact, 15% of the institutionalized group had never been married, a rate two and a half times greater than among the general population. A multivariate analysis, controlling for age, demonstrated that a parent's probability of living in an institution decreased measurably with each additional child he or she had borne. Another demonstration that family support is closely related to elders remaining outside institutions was provided by Brody, Poulshock and Masciocchi (1978) who found no significant difference in the level of disability between clients of home health agencies and private, skilled nursing homes. They found that the major characteristic differentiating these two populations was the availability of a living spouse or children. Townsend (1965) and Maddox (1975) have also noted that the absence of family care is a critical factor in the institutionalization of the chronically ill elderly.

Several studies have demonstrated that elderly people turn to family members in times of stress and Shanas (1979) has noted that this is particularly true when physical assistance is needed. Kohen (1983) found that elderly married and widowed women were more likely to talk to family members about worries and to turn to their children in crisis situations than to friends. He also found that widowed men were much less likely than women to discuss their problems with either close friends or relatives. Beckman and Houser (1982) found that widowed,

childless, older women were psychologically less well than widowed mothers and that this pattern was even more pronounced among women who were physically incapacitated. In addition, childless elders seem to be more socially isolated than those with children (Tunstall, 1966; Johnson and Catalano, 1981).

In a study on the relationship between non-institutionalized elderly people and their relatives, Abrahams and Peterson (1978-79) discovered that the quality of the relationship was correlated to mental health. After interviews with the elderly subjects in the study, researchers rated the relationship between them and their spouses and children as either average or poor. Those subjects rated as having poor relationships with their children were significantly more emotionally disturbed than those with average relationships. A similar finding was made relative to relationships between spouses, although the study produced far fewer ratings of relationships with spouses than with children. Unfortunately, Abrahams and Peterson did not interpret their findings. It is not clear if the mental impairments affected the relationships, poor relationships affected the mental disturbances, or both.

Relatively little research has been done on the relationship between the proximity of the family member providing support and the effectiveness of the support. Litwak (1965; 1981) indicated that affective ties between parents and children can be maintained without physical proximity and Lee and Ellithorpe (1982) found that the quality of the relationship was not related to the amount of contact. A review

of the literature by Moss, Moss and Moles (1985) pointed out that telephone contacts are more intimate than letters. Although they were unable to locate any article which addressed the overall content of the communication, Moss et al. postulated that a level of intimacy may be missing from contacts that are not face-to-face because each party may omit mentioning minor problems in an effort to reduce the other's worry and burden. Although some emotional and social support can be provided, other kinds of help (e.g. physical assistance, supervision of community support services) cannot be given when families are far apart. Little is known about various aspects of the relationship or effects on perceived support when a distant parent becomes ill and/or stressed.

Institutionalized Elderly

Although the percentage of the elderly population residing in institutions at any particular time is relatively small, the proportion of older people who spend some time in an institution is rather large. According to Kart, Metress and Metress (1978), 4.8% of the elderly reside in institutions at any given time, but that low percentage must be balanced by the much higher figures determined by longitudinal studies. When Palmore (1976) reviewed the cases of 207 elderly subjects from 1955 until all had died in 1976, he discovered that 26% had been institutionalized in some type of extended care facility one or more times. Additional evidence of the high rate of institutionalization at some point in the life of the elderly can be found in Kastenbaum and

Candy's (1973) discovery that 20% of all death certificates indicate that death occurred in a long-term care facility.

For the most part, institutionalization means residence in a nursing home. Kart, Metress and Metress (1978) found that 82.2% of the institutionalized elderly live in old age institutions, such as nursing homes and rest homes, and that 11.7% reside in psychiatric hospitals. It should be noted, however, that these ratios probably have changed in the last decade as the result of the transfer of clients from hospitals to nursing homes.

The residents of old-age institutions are predominantly over the age of 75, female, white and widowed (Kart et al., 1978). Of all of the elderly in their sixties, less than 1% reside in institutions; of those in their seventies, about 3% are institutionalized; and of those in their eighties, more than 14% are in long-term care facilities (Tobin and Kulys, 1981). Eighty-three percent of those residing in institutions are 75 years or older, while only 37% of the elderly residing in the community are 75 or older (Lawton, 1981).

As mentioned in the previous section, the primary reason for the institutionalization of the elderly is their inability to care for themselves physically and lack of assistance from family members.

While there have been numerous studies on factors correlated with mental health among community-residing elders, there have been no such studies on institutionalized elders. In the absence of such studies, we may gain some insight from the research conducted concerning life-satisfaction, since, as Lowenthal, Thurner and Chiriboga (1976)

have pointed out, people experiencing general life-dissatisfaction are at greater psychological risk than those experiencing life-satisfaction.

The very act of entering a nursing home is an extremely stressful event (Borup, 1983), the greatest stress occurring during the period immediately after entering the facility (Tobin and Liberman, 1976). The perception elders have of the facilities in which they reside tends to influence their adjustment, with residents who accept living in a nursing home showing significantly better adjustment (Simms, Jones and Yoder, 1982). When Gelfand (1968) studied physically able residents in a nursing home, he found that those who visited outside the home were better adjusted than those who did not leave the home. Gelfand attributed that finding to the visits, but it may have been the result of another factor. Gelfand's own tests on his subjects indicated that those who made outside visits had higher rates of sociability than those who did not. Noelker and Harel (1978) interviewed 125 residents of 14 nursing homes in order to gather information on a variety of variables designed to assess their perception of the facility, well-being and control over where they reside and expressed satisfaction. They found that two factors greatly influenced people's adjustment to institutions: their acceptance of where they were and their ability to control their own environment. In the process of relocating from their own homes to nursing homes, less impaired elders who relocated voluntarily into what they considered to be a better environment and who maintained control over that environment, not only survived longer, but, in some instances,

experienced improvements in their personal well-being. A positive perception of the facility and of other residents, as well as an expressed desire to live in the facility, were significantly associated with morale, life-satisfaction and satisfaction with treatment. This suggests that residents' subjective perceptions of the institutional environment are critical factors for personal well-being. Several other studies (Streib, 1971; Schulz and Alderman, 1973; Schulz, 1976) have also demonstrated that loss of control among elderly nursing home residents was partly responsible for depression, physical decline and early death.

After people have been in a nursing home for some time, several additional factors appear to play a significant role in their adjustment. Harel (1981) investigated the importance of continued ties to possessions and people, integration into the surrounding environment, personal life-space, personal responsibility and social needs on the morale, life-satisfaction and satisfaction with treatment expressed by people who had resided from one to five years in 14 nursing homes. He discovered that continuing ties with people, personal responsibilities and meeting social needs was of the greatest importance in determining morale, life satisfaction and satisfaction with treatment. He found that continuing ties with people the elderly residents preferred to see was more important than the quantity or frequency of visitors. He also discovered that having possessions and going outside the facility may be less important than is generally assumed and had been indicated by Gelfand's work (1968).

Placement of the elderly in nursing homes often strains the relationship between them and members of their families (Tobin and Kulys, 1981). Upon being admitted to a nursing home, individuals frequently experience a feeling of being abandoned and rejected by their families, although the feeling of rejection may lessen as the residents settle in and become involved with their fellow residents and the staff. For some residents of nursing homes, the situation raises problems in their family relationships which are persistent, but often veiled. Even under the best of circumstances, a considerable number of relationships may be affected. Smith and Bengtson (1979) studied the family relationships between elderly nursing home residents and their middle-aged children in what would appear to be a much better than average situation. The residents were predominantly middle class Scandinavian-Americans with very strong family ties. The nursing home was very popular and it went out of its way to encourage the continuation of family ties. Despite these advantages, 10% of the parent-child relationships were negatively affected by institutionalization. The children who reported a deterioration in the relationship often expressed guilt about having placed their parent(s) in the home. The institutionalized parents often expressed anger and manifested demanding behavior. This rather high rate of impaired relationships suggests that potential stress from dysfunctional relationships is a frequent and real problem.

In addition to the problems resulting from adjustment to life in a nursing home and the impairment in family relationships, nursing home

residents face extreme difficulties related to their environment. Frequently the lack of environmental stimulation and activity result in depersonalization, withdrawal, and personal isolation (Coe, 1965; Kahana and Coe, 1969; Jacobs, 1969). Lieberman (1969) has provided the following summary of the characteristics of the institutionalized elderly reported in numerous studies: depressed, unhappy, intellectually ineffective, possessing a negative self-image, docile, submissive and having low interest in their surroundings. Lawton (1981) suggested that the passivity observed in institutionalized elders is due to the inadequacy of their environment. He posited the "Lawton-Nahemow environmental docility hypothesis", according to which diminished competence results in an increased need for environmental stimulation and that the lack of such stimulation has a negative influence on behavior and affect. Support for this proposal can be seen in the numerous studies which have shown that negative environmental features adversely affect the psychological well-being of older people (Lieberman, 1974; Wolk and Telleen, 1976; Lawton, 1977). Conversely, there is evidence that institutional environments which feature individualized care and foster autonomy and integration have residents with higher morale, better life-satisfaction and better adjustment (Bennett, 1963; Coe, 1965; Lieberman, 1974; Noelker and Harel, 1978).

Underutilization of Mental Health Services

The underutilization of mental health services by the elderly has

been documented by many investigators (Rechtshaffen, 1959; Kramer, Taube and Redick, 1973; Khan, 1974; Knight, 1978-79; Redick and Taube, 1980; Butler and Lewis, 1982; Waxman, Carner and Klein, 1984). As was noted earlier in this paper, only 4.5% of the clients seen in community mental health centers and only 2% of the clients seen in private practice are over the age of 65 (Redick and Taube, 1980). As early as 1959, Rechtshaffen noted in his review of the literature on psychotherapy with the elderly that the practice of therapy with them was very limited compared to the amount of therapy carried out with the general adult population. This has changed very little in subsequent years. In his review of the literature published after Rechtshaffen's review, Knight (1978-79) pointed out that there has been a growth in awareness of the problems faced by older people and that there has been a renewal of interest in the aging process, but he also notes that there has not been a significant increase in service utilization by elders.

Reasons for the Underutilization of Mental Health Services

Possible explanations proven false. As a result of the considerable research into the reasons for this low utilization rate, several possible factors have been clearly excluded. The underutilization of mental health services is not due to a reluctance by the elderly to use medical services in general, nor is it the result of an ineffectiveness of psychological treatment among elderly populations, nor is it the result of any lack of need.

Elders are disproportionately heavy users of medical services (Anderson, 1974; Kart, Metress and Metress, 1978; Haug, 1981). Usage is

particularly frequent among females and those who are less well educated. Haug (1981) noted that medical services often result from trivial complaints and speculated that there may be secondary gains involved, although he did not expand upon that theme.

There have been numerous reports on the effectiveness of psychotherapy with elderly clients (See the following review articles: Rechtshaffen, 1959; Willner, 1978; Knight, 1978-79; Sparacino, 1978-79; Yesavage and Karasu, 1982), although descriptions of therapeutic approaches are frequently vague and anecdotal, and could be dismissed as methodologically flawed, as Sparacino (1978-79) has noted. The wide variety of effective psychotherapeutic approaches include psychoanalytic treatment (Meerloo, 1955; Grotjahn, 1955), group therapy (Shere, 1964; Liederman and Green, 1965; Post, 1965; Stotsky, 1972; Stenback, 1973; Rosen and Rosen, 1982), behavioral and cognitive therapies (Rimm and Masters, 1974), brief therapy (Goldfarb, 1955a; 1956) and family training procedures (Pinkston and Linsk, 1984).

Contrary to widespread belief, psychotherapy has been successful with the cognitively impaired elderly as well as with those who are not impaired. Goldfarb (1955b) and Wolf (1963; 1970) have demonstrated that psychotherapy can be adapted and used effectively with institutionalized elderly with mild to moderate organic brain disorders. Ronch and Maizler (1977) have conducted successful, in-depth psychotherapy with elderly nursing home residents. Although Ronch and Maizler published their results in order to counter the common assumption that only consultation and non-insight oriented techniques are viable approaches

with this population, their results have had little impact on practitioners.

The elderly appear to be in considerable need of mental health services. Coulton and Frost (1982) found that 21.5% of the 1,834 non-institutionalized elders they interviewed had used some service for mental health reasons within the previous twelve months, including visits for psychotherapeutic or pharmacological treatment for nervous or mental disorders provided by both medical and non-medical mental health professionals. Unfortunately, they did not provide a more detailed breakdown on the categories of services provided.

Elderly people experiencing symptoms of mental illness often perceive themselves to be in need of treatment. In Christenson and Blazer's study (1984) of non-institutionalized elderly subjects, 50% of those experiencing paranoid ideation perceived a need for counseling and medication for "nerves." Of the subjects identified as having a primary or secondary depression, 43% reported a need for medication and 22% expressed a need for counseling. Only a fraction of the subjects in each of these categories had actually received treatment. These patterns were similar to those discovered by Blazer and Williams (1980) in their survey of elderly people in a community; 22% of those they identified as depressed perceived a need for counseling, but only 4% were actually receiving treatment.

Barriers to Treatment

The factors which actually do cause the underutilization of mental health services by the elderly, commonly referred to as "barriers to

treatment", have been studied by several researchers (egs. Gaitz, 1974; Knight, 1978-79; Levy, 1981) and were noted as early as 1959 by Rechschaffen. The literature identifies the following ten principle categories of barriers, each of which will be described in some detail: therapists' attitudes and issues, elders' attitudes about therapy and therapists, therapists' lack of education concerning and experience with elders, the cost of treatment, transportation problems, lack of awareness of services, differential patterns of referral of younger and older people, consequences of the symptoms of mental illness, the use of medication instead of treatment and the failure of clients to enter therapy following referral.

Therapists' attitudes and issues. This category has received the most extensive attention, probably because of the availability of therapists for study. In general, therapists have been reluctant to work with the elderly. On average, psychiatrists devote only 2% to 4% of their professional time to the treatment of the elderly (Butler and Sulliman, 1963) and, among psychiatrists in private practice, the most frequent form which this work takes is consultation concerning institutionalization (Butler, 1975; Marmor, 1975).

A primary reason for this pattern was the pervasive view which Freud had concerning the inapplicability of psychotherapy to old people because of their increased rigidity, their diminished cognitive capacity and the overwhelming amount of material to process due to their long histories. This pessimistic view persists to this day. As recently as 1985, Ray, Raciti and Ford demonstrated that psychoanalytically and

psychodynamically oriented psychiatrists continue to have substantial prejudice against older patients, who are viewed as less ideal for their practices. They also make more negative prognoses for the elderly than they make for their younger patients.

This pessimistic view by psychiatrists seems to be shared by other professionals in the mental health field. When they surveyed 220 students and professionals working in the fields of social work, psychology, and nursing, Wolk and Wolk (1971) found that 80% preferred not to work with the aged. A number of investigators have postulated explanations for this pattern (Kastenbaum, 1963; 1964; Bromley, 1966; Coe, 1967). Some of these ideas were summarized in a report by the Group for the Advancement of Psychiatry (Cohen, 1976) which provided the following list of factors which may affect a therapist's desire or willingness to work with the elderly:

1. The aged stimulate the therapists fears about his own age.
2. Elderly patients arouse the therapist's conflicts about his relationships with parental figures.
3. The therapist thinks he has nothing to offer old people because he believes that they can not change their behavior or that their problems are all due to untreatable organic brain disease.
4. The therapist believes that his psychodynamic skills will be wasted with the aged because they are all near death and not as deserving of attention.
5. The patient might die while in treatment, which could

challenge the therapist's sense of importance.

6. The therapists' colleagues may be contemptuous of his efforts on the behalf of aged patients. There is a belief on the part of some that gerontologists or geriatric specialists have a morbid preoccupation with death; their interest in the elderly is considered to be "sick" or suspect." (pp. 65-66)

These issues have been reiterated and, in some cases, elaborated upon by a number of investigators (Gaitz, 1974; Patterson, 1976; Cohen, 1976; Rubin, 1977; Gaitz and Varner, 1980). For example, Kastenbaum (1963) suggested that psychotherapists may fear that treating populations that are low in status will negatively influence their own status as professionals.

Elders' attitudes about therapy and therapists. Many elders have attitudes about psychiatric care which cause them to be reluctant to seek help. They are apt to view psychological difficulties as a normal part of the aging process (Sparacino, 1978-79) and/or they tend to perceive mental illness as an inherited condition from which there is no recovery (Riley and Foner, 1968). In addition, many elders view psychotherapy as a sign of weakness or disgrace, rather than a sign of urbane sophistication and efficient coping (Raskind, Alvarez, Pietrzyk, Westerlund and Herlin, 1976; Sparacino, 1978-79). Butler and Lewis (1977) cited a number of reasons why the aged may resist mental health intervention into their lives, including a fear of change, a desire for independence and an often valid assessment of the inadequacies of most

existing mental health services for the elderly. Sparacino (1978-79) also noted several cohort differences which may be significant factors, such as the fact that, in comparison with the general population, people who are now elderly tend to be more conservative and are less concerned with preventative medical care. As examples of this lack of concern, he stated that elders were more reluctant than other adults to go for a regular physical examination, eat a balanced diet and exercise.

Support for some of these points can be found in a study conducted by Patterson (1976). While surveying a group of eight mental health centers, he interviewed elderly people at local senior centers who were not receiving any mental health services in order to discover their perception of the availability of services. The subjects responded to his questions about mental health problems with anxiety, often expressed by nervous joking. Many said that mental health services were only for "crazy" people and they associated mental problems with long periods of hospitalization. Some who admitted that they had experienced problems with depression, anxiety and psychosomatic illness, reported that they had not considered it appropriate to take these problems to mental health professionals. Unfortunately, Patterson reported his findings in an anecdotal format, neither providing statistical analysis nor explaining whom, if anyone, his subjects would see for their psychological problems.

Generally, if people tell anyone other than a relative or a friend of their psychological problems, they will tell a medical professional. In a continuation of Brody and Kleban's work (1983), Waxman, Carner and

Klein (1984) interviewed 88 community-residing elders concerning their attitudes toward mental health and their speculation about who they would see if they thought that they need help. Only 36.9% of the subjects indicated that they would tell a health professional about depression. The remainder reported a preference for telling a friend or family member (41.7%) or for keeping it to themselves (21.4%). The subjects expressed a far greater willingness to tell a health professional about organically based disorders, with 58.3% saying they would do so in the case of organic brain disorder and 71.8% in the case of cardiovascular symptoms. When asked from whom they would seek professional help for psychiatric symptoms if they desired assistance, the overwhelming majority (88%) said they would choose a physician. They also overwhelmingly (79.5%) perceived the general physician as being the most effective in treating psychiatric symptoms. By comparison, mental health professionals fared very poorly; only 19.2% thought that any of the mental health professionals listed on the questionnaire (psychologist, psychiatrist, social worker) would be the most effective in treating depression and even fewer (8.4%) thought that they would be the most effective in treating organic brain disorder.

Waxman, Carner and Klein found that these attitudes were significantly related to the subjects' selection of professionals to whom they would turn for help. Those with positive attitudes were more likely than those with negative attitudes to perceive themselves as seeking professional help for symptoms of depression. However, attitude scores were not significantly related to the elders' choice of a

particular health professional nor to their opinion about which professional would be the most effective for either set of psychiatric symptoms. Subjects over the age of 75 were significantly less likely than young-old subjects to perceive themselves as telling a health professional about symptoms of OBS (39.4% v. 70.6%) or depression (29.9% v. 41.5%). Subjects who scored high on the depression scale were more likely than subjects who had moderate or low scores on the depression scale to visit their physician (mean = 13 visits during the previous year), but they reported that a mental health professional would be more effective in treating their symptoms of depression.

The preference by elders for services from a general practice physician over services from a mental health professional suggests that the elderly lack knowledge concerning the work of mental health professionals and/or lack confidence in their ability to help. This can probably be attributed to generational differences. It seems highly probable that the aged of the future will demand far more mental health services because they will be better educated and will be more familiar with psychological procedures (Sarason, Sarason and Cowden, 1975; Birren and Renner, 1981).

Therapists' lack of experience with and education about elders. As Geitz (1974) has pointed out, the behavior of mental health providers is strongly influenced by their own rather negative attitudes about the elderly. The large number of therapists who have little experience and training with this population often believe that the problems of the elderly are unsolvable, that aging is accompanied by a decline in

functional capacity and that the prognoses for mentally ill elders are poor. Gaitz does, however, hold out the possibility that such attitudes can be overcome through education, training, and increased experience.

The likelihood of solving this problem by means of education and training is not good, however. Psychologists have not been diligent in educating themselves about working with the elderly (Lawton and Gottesman; 1974) and few psychotherapists have had sufficient training in the treatment techniques most suitable for the aged (Busse and Pfeiffer, 1973; Pruchno and Smyer, 1983). Many investigators have pointed out that inadequate preparation in medical schools and clinical psychology programs in both research skills and clinical experience disinclines therapists to work with the elderly and limits their effectiveness when they actually do work with the aged (Kastenbaum, 1963; Butler, 1969; Butler and Lewis, 1982). As Butler (1969) has noted, training often concentrates on young patients with acute disorders. At the present time there are few training settings available for those interested in aging and mental health (Storandt, 1977; Dye, 1978; Siegler, Gentry and Edwards, 1978). Consequently the training of specialists in the mental health of elders is acquired "on the job," as is probably true in most fields of specialization. Unfortunately most psychotherapists encounter few elderly clients with whom they may extend their range of skills. Cohen (1976) has speculated that therapists may avoid elderly clients because they are uneasy about the possibility of being overwhelmed by the diversity of problems an

older person might present. Lawton and Gottesman (1974) have recommended that the situation might be improved by the requirement of extension courses for those who spend a good deal of their time with elders.

Cost of treatment. The cost of psychotherapy is an obvious, but frequently unmentioned, barrier to treatment. A large proportion of the elderly live on incomes that fall below the Federal poverty level (Butler and Lewis, 1982). The two government-managed medical assistance programs most frequently used by the aged, Medicare and Medicaid, have inadequate provisions for mental health services and encourage institutional care over out-patient or community-based programs (Knight, 1978-79). As Butler and Lewis (1982) have noted, Medicare coverage for inpatient treatment of psychiatric disorders is unrealistically limited.

Transportation problems. Several investigators (e.g. Gaitz, 1974; Cohen, 1976; Patterson, 1976) have identified lack of transportation as one of the barriers which prevent the elderly from using mental health services. This was disputed by Sparacino (1978-79) who pointed out that the elderly manage to make far more trips to physicians than younger people do. Support for that criticism may be found in the study on elders' attitudes concerning mental health services conducted by Waxman et al. (1984). Although the subjects were residents of an urban community with good access to a variety of forms of transportation to several different health services, including a community mental health center, they did not seek help from mental health professionals because

they had negative perceptions of them.

Lack of awareness of services. In his survey of mental health centers, Patterson (1976) identified an additional barrier which is rarely mentioned by others. The majority of centers Patterson studied did very little to educate the elderly about mental health or to familiarize them with the services they offered. Even more surprising, the centers did not inform other agencies about their services, although many of these agencies might be expected to refer clients to the mental health centers. Some were under the mistaken impression that the centers did not wish to treat elderly clients.

Differential patterns of referral of younger and older people. As noted earlier in the section on elders' attitudes, when elders do turn to a professional for help with their mental illnesses, they are most likely to see a general practice physician. As a result, physicians and clergymen are the primary providers of aid for older people with personal problems (Gurin, Veroff and Feld, 1960). Although the general practice physicians, to whom the elderly are most likely to turn, are not usually specialists in psychiatry (Riley and Foner, 1968), they generally do not refer these patients to specialists for psychotherapeutic treatment. Kucharski, White and Schratz (1979) conducted a study on the referral patterns of physicians in which they told vignettes about eight patients of various ages with obvious psychiatric symptoms. Although the symptoms of clients of all ages were of equivalent severity, the physicians were much more likely to refer younger patients for psychiatric treatment than they were to refer older

patients.

Abrahams and Patterson (1978-79) have proposed that one of the reasons why physicians often do not refer their elderly patients for mental health services is that they often work in isolation and may not be familiar with community agencies. They suggested that the frequency of referral might be increased by informing physicians about psychiatric problems of the elderly and the agencies and services available for them.

Physicians are not the only people unlikely to refer the elderly to mental health specialists. The relatives of elders frequently do not suggest that they seek professional help, even when it is obvious that they have symptoms of mental illness. Gaitz (1974) noted that relatives often have the same negative impressions about mental illness and mental health care that were described in an earlier section of this paper as typical of elders. Consequently, it may be that spouses and children are just as reluctant as elders to admit that there are problems and a need for professional help. In addition, they often fear offending the elderly members of their family by suggesting that they need psychiatric care (Butler and Sulliman, 1963).

Consequences of the symptoms of mental illness. Some of the symptoms of certain mental illnesses may also function as barriers to treatment. Reifler, Cox and Hanley (1981) have suggested that demented elders may not have the ability to comprehend their problem and, even if they do, they may not be able to make the necessary arrangements for the help they need. Reifler et al. support this argument with their finding

that cognitively-impaired clients usually tend to significantly underestimate the severity of their situation, in comparison with the evaluations made by relatives or mental health professionals. They also note that the depressed aged often believe that nothing can be done to help them and that the paranoid aged are often suspicious of everyone.

Use of medication instead of treatment. There is a tendency to rely upon pharmacological treatment rather than psychotherapy as a response to the mental illnesses of elderly people. In large part, this is probably related to the fact that when elders need help they turn to their general physicians more often than to anyone else. Since these physicians usually lack the time and training necessary to carry out therapy (Gaitz and Varner, 1980) and may not be aware of mental health services available to the elderly, they often prescribe medications to alleviate some of their patients' symptoms. Another factor is that the mental health professionals who are most likely to work with the elderly usually have a medical orientation. Ray et al. (1985) found that psychiatrists recommended pharmacotherapy alone or in combination with psychotherapy more frequently for older people than for younger people. Palmore (1973) noted that residents of nursing homes are given excessive amounts of sedatives and tranquillizers in an attempt to reduce their complaints. It is probable that some of these complaints are symptoms of mental illness which could be treated by therapy.

Failure of clients to enter therapy following referral. Failure to attend therapy following referral is a common problem among the elderly, just as it is among the adult population in general (Raynes and Warren,

1971). When Raynes and Warren (1971) examined 267 referrals to a psychiatric outpatient clinic of a city hospital, they found that 113 (42.4%) of them did not attend even their first appointment. Twenty-one (7.8%) of the clients referred were over the age of 60, and nine (42.8%) failed to attend therapy.

Raynes and Warren (1971) tested to see if the rate of follow-through on referral was related to other factors. They found that there was no significant difference between male and female clients. They did discover that clients referred by physicians, social agencies and themselves were slightly more likely to follow-through than those referred from hospitals (egs. clinics, wards, accident and emergency units), although the degree of difference was not significant. They found no significant relationship between follow-through and marital status. Unfortunately they did not specifically examine the patterns of referral and follow-through among elders.

Raynes and Warren (1971) did find a relationship between follow-through and the use of waiting lists. Not surprisingly, the percentage of clients who did not attend therapy increased with the length of the waiting period. Half of the clients who had been on a waiting list from six to twenty-five days, failed to attend therapy; the non-attendance rate jumped to 75% for those who waited more than twenty-five days. As Baekeland and Lundwall (1975) pointed out, clients may become tired of waiting and go to another treatment facility or change their minds about the need for therapy. They also suggested that the clients problems may become less acute as time passes. Raynes and

Warren found that 72% of the clients who referred themselves did attend therapy despite being on a waiting list, a pattern that can probably be attributed to the fact that the client who is motivated to contact a clinic would also be sufficiently motivated to attend therapy. On the other hand, clients who reported difficulty in dealing with a recent death or reported having a "nervous breakdown" as their presenting symptom, had extremely high rates of non-attendance at therapy (100% and 86.7% respectively). Raynes and Warren attributed these findings to resolutions of the problems while the clients were on a waiting list.

Community Mental Health Services

Despite the fact that the most promising approach to providing better mental health treatment for older people appears to be community-oriented prevention and treatment services offered through community mental health centers (Gurian and Scherl, 1972; Santore and Diamond, 1974; Knight, 1978-79; Lowy, 1980), access to such services is inadequate (Hagebak and Hagebak, 1980; Birren and Renner, 1981). Since 1975, a congressional mandate (Public Law 94-63, 1975) has required all federally funded CMHCs to provide, as one of their 12 basic services, "a program of special services for the mental health of the elderly including a full range of diagnostic, treatment, liaison, and follow-up services." A number of CMHCs have responded to this mandate by integrating the elderly into their existing service system. Although this approach can be supported on the basis of its non-discriminatory

orientation, it has often served to minimize the delivery of services to elders (Hagebak and Hagebak, 1980). In most agencies, the pattern has been to designate a nurse or social worker as a geriatric coordinator. While this approach is consistent with the recommendation of the Group for the Advancement of Psychiatry (1971) that a person be designated to act as an advocate for the aged in the community and to train other staff in recent developments in gerontology, the centers which have adopted this approach tend to provide the program little support and give it low priority. In part, the limited response of CMHCs to the federal policy on mental health for the elderly can be attributed to demands from the federal government and other funding and monitoring agencies for increased attention to the problems of other populations, such as children, alcoholics, and drug addicts (Santore and Diamond, 1974). Other factors include inadequate funding, uncertainty over which approaches are the most cost-effective, and many of the barriers to treatment discussed previously in this paper. Indeed, some programs have defended the low usage of their services by the elderly by pointing to the reluctance of members of that age group to use them in the first place (Pratt and Kethley, 1980).

There are very few CMHCs which provide services designed specifically for the elderly (Gaitz and Varner, 1980), and even fewer have been reported on in the professional literature. A search conducted as part of this study located only nine articles describing community-based mental health services for elders. Seven concerned programs designed exclusively for the elderly; the eighth (Winogrand and

Mirassou, 1983) described a mobile crisis intervention program serving clients of all ages; the ninth article (Patterson, 1976) reported on a survey of eight CMHCs to determine what services they provided to older persons. Four articles described services provided by CMHCs (Santore and Diamond, 1974; Patterson, 1976; Ruffin and Urquhart, 1980; Knight, Reinhart and Field, 1982). Two articles described services for the elderly established by the University of Washington (Reifler, Cox and Hanley, 1981) and Mount Sinai Medical Center (Selan and Gold, 1980). Three articles described crisis intervention programs (Reifler, Kethley, O'Niell, Hanley, Lewis and Stenchever, 1982; Winogron and Mirassou, 1983; Wasson, Ripeckyj, Lazarus, Kupferer, Barry and Force, 1984). The quality of the information provided varied substantially from article to article. Only three of the nine provided supporting data, the remainder were written in an anecdotal manner. What follows is a review of these nine articles as they relate to specific issues concerning the delivery of mental health services to elderly clients.

Sources of Referrals

Most studies reported that elderly clients did not refer themselves for mental health services. In an earlier article about the same geriatric intervention team described by Reifler et al. (1981), Raskind, Alvarez, Pietrzyk, Westerlund and Herlin (1976) reported that only 2% of the clients were self-referred. Other studies reported low percentages as well (Ruffin and Urquhart, 1980--2%; Reifler et al., 1982--4%; Winogron and Mirassou, 1983--9%). Only Knight, Reinhart and Field (1982) in describing a senior outreach team at a CMHC, reported that

"many" elderly clients were self-referred, but they provided no specific data, such as percentages or even the number of clients involved.

Reifler, Cox and Hanley (1981) justified the pattern of accepting referrals from people other than the clients themselves with an argument that the problems most frequently observed among mentally ill elders were more likely to be identified by the client's family than by the client. They also said that their clinical experience suggested that it was not essential for elderly clients to agree with the clinical staff's diagnosis of their problem for them to receive effective assistance. Reifler et al. did not discriminate between the responsiveness to treatment of the cognitively-impaired and that of the unimpaired, which is unfortunate because it is reasonable to expect that the unimpaired clients, like the general adult population, would profit by taking a more active role in their own treatment. Support for this position can be found in the three to four year follow-up study conducted by Reifler, Kethley, O'Neill, Hanley, Lewis and Stenchever (1982). They found that only 12% of the clients served thought that the team had been helpful; the majority had no opinion and probably did not even remember the team's effort. They attributed this low percentage to the fact that clients had not referred themselves and did not play an active role in their treatment.

The variety in the type of services offered and the information provided in the articles does not permit a comparison of the patterns of referral for each of the three types of program (CMHC, outpatient service and crisis intervention). For example, only two of the articles

on CMHC programs (Knight et al., 1982; Ruffin and Urquhart, 1980) were concerned with the source of the referrals. These same two programs were more oriented toward maintenance of independent functioning and reducing the probability of institutionalization, a purpose more in common with crisis intervention than with the traditional, comprehensive services offered by most CMHCs.

For the most part, the source of referrals was linked with the type of service the client needed and with whom the program had developed interagency connections. Family members were the most frequent source of referral to CMHC outreach teams designed to assess and coordinate auxiliary services to maintain independent functioning (Ruffin and Urquhart, 1980; Knight et al., 1982). Knight et al. reported that few referrals came from hospitals and senior service agencies. Ruffin and Urquhart reported that a considerable percentage of referrals came from social service agencies (20%) and visiting nurses (20%), while an additional 30% came from physicians, neighbors, landlords, police and others, although they did not give specific percentages for each of these latter categories.

Families also figured prominently as the source of referral for clients of one of the two outpatient service programs (Reifler et al., 1981). Within the category of family referrals, 39% were made by daughters, 33% were by spouses and 17% were by sons. Reifler et al. also noted that half of the relatives making referrals lived with the client. The other article on an outpatient program (Selan and Gold, 1980), did not report on referrals.

The majority of referrals to the crisis intervention programs came from a professional or some other person not related to the client. The program described by Wasson et al. (1984) received most of its referrals from home health professionals who had significant contact with the clients prior to the referral and who usually were experiencing some difficulty with him or her. This was probably due to interagency connections developed as the team consulted with other agencies about problem-solving strategies. Few referrals came from relatives, due, in part, to the high rate of widowed (80%) and childless (45%) clients. In the other two crisis intervention programs, the majority (Reifler et al. (1982), 81%; Winogron and Mirassou, 75%) of referrals came from a professional or other non-related person. Winogron and Mirassou proposed that the low rate of referral by relatives was probably due to refusal on the part of elders to permit their relatives to make referrals because of fear or an inability to recognize the seriousness of their situation.

No mention was made in any of the nine articles on the rate of referrals from physicians. Health agencies and professionals were mentioned as the source of referral in only one article. Reifler et al. (1982) indicated that 29% of the referrals to a crisis intervention team came from these sources, but did not provide a breakdown on the numbers from each type of medical professional.

Reasons for referrals

Only three of the nine articles included relatively detailed information on the reasons for referrals, and in each of those three

physical dysfunction was a significant factor. Ruffin and Urquhart (1980) reported that two-thirds of the clients referred to their outpatient clinic were gravely disabled and unable to care for themselves due to confusion, severe cognitive impairment or serious physical illness and lack of adequate support. Winogron and Mirassou (1983) found that the majority of the elderly clients referred to their crisis intervention team (which served people of all ages) were experiencing a medical crisis (34%) or physical dysfunction (34%). Reifler et al. (1982) found that the most common reasons for referral to their crisis intervention team were inability to care for self (35%), forgetfulness or confusion (34%), bizarre behavior (28%), depression (16%) and suspiciousness of others (17%). Unfortunately, because several categories overlapped, it is unclear how frequently each problem occurred relative to others. The pattern of the source of referrals in these three studies is understandable given the emphasis in these programs on the maintenance of independent functioning and the dearth of information from more traditional psychotherapeutic services.

A large portion of the referrals were made for clients who were in a crisis situation. Obviously, this was the case for the clients of the crisis intervention teams described in the articles by Reifler et al. (1982) and Winogron and Mirassou (1983). Ruffin and Urquhart (1980) did not explain what portion of the clients in their outpatient clinic were in crisis when they were referred. Such data are available from a CMHC outreach program described by Knight et al. (1982) who found a majority of the clients in crisis when referred. At first this might

seem surprising, since one would expect crisis to be a more frequent characteristic of clients referred to a crisis intervention team in contrast to those referred to CMHCs and/or outpatient centers. On the other hand, one should remember that nearly all these clients were referred by others, and that those making the referrals were probably stimulated by a crisis. Tentative support for this reasoning can be found in Knight et al. (1982), who reported being frustrated by families who waited until a crisis had arisen and Raskind et al. (1976) who made a comment (unrelated to referral) that the "family, social agency, apartment, police department, or whoever found the older person's situation intolerable" (p. 54). As for those who do refer themselves, therapists report that the elderly are so reluctant to seek out mental health services that they often wait until a problem has developed into a crisis before seeking help (Zinberg, 1964; Oberleder, 1966; Busse and Pfeiffer, 1969; Brothwood, 1971).

Demographic Characteristics of Clients

Only four of the articles included information on the demographic characteristics of the clients, three of them being about crisis intervention programs (Reifler et al., 1982; Winogron and Mirassou, 1983; and Wasson et al., 1984) and the fourth concerning a CMHC program (Ruffin and Urquhart, 1980). Women were overrepresented in all four studies (range = 69%-73%) The majority of clients lived alone (range = 60%-71%) and were unmarried (range = 66%-83%). The one article which included information on family support (Wasson et al., 1984), indicated that 60% of the clients had no family on which they could rely. All

three of the studies which reported on income levels (Ruffin and Urquhart, 1980; Reifler et al., 1982; Wasson et al., 1984) reported that clients tended to have low incomes. For example, Ruffin and Urquhart said that 50% of their client population had very low incomes and that this was disproportionately higher than would be expected in the area where the center was located.

Services to Nursing Home Residents.

Only two of the nine articles (Patterson, 1976; Reifler et al., 1982) specifically mentioned services provided to residents of nursing homes, and in both of these studies, they constituted a small portion of the clientele. Nursing home residents were 8% of the caseload in the Reifler et al. (1982) study, but little mention was made of these clients in the report. In his survey of eight CMHCs, Patterson (1976) reported that service to nursing home residents was limited to one inpatient unit and some consultation with staff in facilities where residents displayed behavioral problems which the staff could not effectively manage. It is probable that this general pattern reflects the tendency to underestimate the ability of nursing home residents to participate in psychotherapeutic activities. Additional evidence of the low rate of psychotherapeutic service to this population can be found in Poggi and Berland's (1985) report that they tended to provide physical treatment for psychological symptoms as a way of avoiding dealing with the complex issues presented by residents.

Services to Clients with Organic Brain Disorders

Clients with organic brain disorders figured prominently in the nine

articles, but primarily as recipients of assessment procedures and coordination of support services, as opposed to psychotherapy (Ruffin and Urquhart, 1980; Reifler et al., 1982; Knight et al., 1982; Winogron and Mirassou, 1983; Wasson et al., 1984). An exception to this pattern is the Reifler et al. (1981) article which described a program for elders and their families with a more consultation and family therapy approach to providing mental health services to organic brain disorder clients. They found that these clients frequently underestimated the severity of their situation and often appeared unaware that a problem even existed or that it had any impact on members of their families. To some extent this contradicts the findings of other investigators (eg. Mace and Rabins, 1981) that both younger and older individuals in the early stages of a progressive dementia experience severe depression and frequently produce maladaptive and bizarre behavior in an effort to appear normal to others.

Type and Quality of Services Provided

There was considerable variation in the type and quality of the mental health services provided by the programs covered by the nine articles. Two of the three crisis intervention teams (Reifler et al., 1982; Wasson et al., 1984) were heavily medical in their orientation. There is some justification in that approach, particularly considering Winogron and Mirassou's (1983) finding that a medical crisis was the most frequent reason for the team's intervention with individuals over the age of 60. However, the medical orientation resulted in several distinct patterns: clients played an extremely passive role in their own

treatment, with their significant others making most of the decisions; evaluation and treatment were usually accomplished in only one or two visits; there was a tendency toward quick-fix solutions; and a relatively high rate of institutionalization and medication occurred following contact with the intervention team. For example, Reifler et al. (1982) reported that 23% of their clients were moved to a "new location" as part of their treatment; however, most of them went to nursing homes and hospitals; only 2% went to another community-based living situation. Wasson et al. (1984) reported that 12% of their clients were placed in nursing homes following contact with the intervention team. Reifler et al. (1982) reported that medication was widely employed as a form of treatment. In 14% of their cases the main recommendation was an adjustment in medication, including starting the client on antipsychotic drugs. Ruffin and Urquhart's (1980) description of a CMHC program did not provide a percentage of the cases in which medication was employed, but a fairly lengthy section was devoted to the use of psychoactive medication and the establishment of therapeutic levels.

The limited information in the other articles does not permit analysis of the treatment methods they employed. Little emphasis was placed on psychotherapy in any of the programs, even those which were based in a CMHC. In the crisis intervention program described by Wasson et al. (1984), only 77% of the clients received direct psychiatric services of any kind (egs. psychotherapy, psychotropic medication, hospitalization) and the main recommendation in 47% of the cases was for

increased medical or social services. Some referral for psychotherapy was reported in the CMHC program described by Knight et al. (1982), but this was usually for clients and/or families who did not show improvement following other treatment approaches which had been tried.

Three of the articles (Santore and Diamond, 1974; Patterson, 1976; Selan and Gold, 1974) provide little information of use in this study. Santore and Diamond (1974) described a "multi-faceted" program developed by a CMHC in collaboration with a group of local clergymen and their churches. The project recruited and trained a cadre of older aides, who then developed outreach and casework services for crisis intervention, counseling, transportation, nutrition and social involvement. Very little attention seems to have been given to dealing with psychological disorders in need of sophisticated treatment. In fact, there was no mention of any mental health professional being involved in the program. Given its focus on other services and its superficial treatment of psychological disorders, the program would more suitably be associated with a senior center than a CMHC. This report does serve to demonstrate how mental health services often lose when they are in competition for attention with other social services, such as transportation, nutrition, and physical health.

The Selan and Gold (1980) article is an anecdotal report on a mental health program based in an outpatient clinic at the Mount Sinai Medical Center. It contains insufficient detail to permit analysis on the type or quality of services provided.

The third article resulted from a study contracted by the National

Institute for Mental Health. Patterson (1976) reviewed eight CMHC programs for the elderly and found all the services to be minimal. Unfortunately, much of the information Patterson provided was anecdotal and does not lend itself to analysis.

Although Patterson was unable to find an effective mental health program, his interviews with staff, elderly clients, and a variety of people familiar with the mental health needs of the elderly in the community (e.g. staff at public welfare offices, nursing home personnel, elders at senior centers) enabled him to make several recommendations for the delivery of mental health services to elders. His first recommendation, that every mental health center should have a staff person designated as an advocate for the elderly, has been widely accepted and implemented.

Patterson's second recommendation was that services for the elderly should be integrated with the clinical services for other adults, largely because segregated services within CMHCs are likely to be inferior because of the low status elders are accorded in our society. This recommendation is subject to question because, as several investigators (e.g. Reifler, Cox and Hanley, 1981; Knight et al., 1982; Wasson et al., 1984) have demonstrated, the elderly have special needs and problems such as organic brain disorders, need for outreach services, and need for consultation with persons in the aged client's environment. Given the high turnover of clinicians in many mental health centers, it would be difficult to keep all staff educated as to the needs and services available to the elderly client. It may be that

services to the elderly should be as similar as possible to those given to other adults, but taking the special needs of the population into consideration. For example, those CMHCs which have divided their clinicians into teams, each specializing in a client population (egs. children, families, adolescents, adults, chronics) could establish a senior team patterned after services provided adults, but with its specially trained therapists prepared to meet the needs of aged clients.

Patterson also recommended that services should be delivered to nursing home residents as well as to elders residing in the community. He noted that the services provided to nursing home residents in the eight programs he surveyed consisted mainly of consultation with nursing home staff on a case by case basis. He suggested that such consultation be replaced by in-service training for nursing home staff members and "policy-oriented changes" which would have greater long run impact. While such training would certainly be useful, total reliance upon this approach would suggest that the problems which arise among nursing home residents are entirely predictable and capable of being resolved without professional intervention. It is unrealistic to expect nursing home employees who have participated in an in-service training program to develop therapeutic approaches to every client's problem. Such training would not provide sufficient expertise to permit staff to devise plans to deal with problems residents experience because of their environment. For example, as Gaitz (1974) has correctly pointed out, the person commonly designated as the client is not always the person in the

greatest need of service nor is he or she the person on whom attention should be focused. What appears to be a simple delivery of service to a client must be viewed as a complex process involving several individuals. Such capabilities are unlikely to result from limited in-service training provided to nursing home staff members.

Patterson also recommended that services be provided through outreach efforts, specifically via satellite facilities and home visits. Similar views were expressed by the authors of all the other eight articles reviewed in this section. While some may view outreach as more appropriate for crisis intervention and brief therapy programs, there is evidence that outreach is both feasible and suitable for on-going counseling. For example, Cohen (1976), a psychiatrist, described the feasibility of carrying out individual psychiatric treatment with elders on a weekly basis in a senior housing complex. Selan and Gold (1980) asserted that home visits may be more comfortable and less threatening for the vast number of elderly people who are fearful of psychiatric care.

Drop-out

Clients who drop out of therapy have been of interest to investigators for a number of reasons. Clients who fail to attend a clinic after the intake procedure represent a considerable expenditure in terms of both professional investment and time. It is also obvious that clients who drop out of therapy gain less professional help than they

would if they continued (Raynes and Warren, 1971). If clients who are likely to drop out could be identified and their negative response to the clinic more fully understood, it might be possible to introduce more effective programs and to increase the rate of persistence in therapy.

There is a high drop-out rate and it is a real problem. When Baekeland and Lundwall (1975) reviewed the literature on this topic, they found that between 20% and 57% (depending upon the article cited) of the general psychiatric population failed to return after the first visit to an outpatient clinic. Between 31% and 56% attended no more than four times. In fact the mean or median number of visits ranged from only three to 13 in the 12 articles they reviewed.

One problem with the research on this topic is that the definition of dropping out is not standardized because of the wide variety of theoretical perspectives among therapists. Some therapists, particularly those with a psychoanalytic orientation, advocate extended treatment, which results in a perception that clients who drop out after 13 to 21 visits are in a "failure zone" (Baekeland and Lundwall, 1975). On the other hand, Baekeland and Lundwall also pointed out that clients with some situational problems may derive little benefit from extended treatment and may drop out after they have received what they wanted from therapy, which is usually symptomatic relief and/or support during the resolution of an acute life problem. Support for that position can be found in the work of Straker, Devenloo and Moll (1967), who found that 72.7% of the drop-outs from individual psychotherapy who had completed at least 11 sessions, reported that they were well and

symptom-free at the time of a two-year follow up. The number of treatment sessions can also vary with the therapeutic approach employed. For example, brief therapy, which focuses on resolving a problem agreed upon by the client and the therapist, tends to average only 10 to 12 sessions (Straker, 1968). Under these circumstances it seems reasonable to define dropping out as leaving therapy after less than 10 sessions.

It should also be noted that dropping out is usually defined in terms of the number of therapy sessions, rather than the length of time that a person is in therapy, because the length of the treatment session is standardized but the frequency of treatment is not; thus two people who attend a clinic over the same period of time may have a very different number of treatment sessions.

There have been no studies on the specific reasons why elderly clients, in particular, drop out of therapy. This can be attributed to the recent focus of attention on why elderly clients do not enter therapy in the first place and to the rather small size of the elderly population in therapy which could become the subject of research.

Consequently, it is necessary to turn to the research on the general adult population to find any scientific information on drop-outs. Such studies have usually concerned adult outpatients in individual psychotherapy and have focused on such client factors as demographic, symptomatic and personality variables.

Both age and gender have been implicated in client drop-out in several studies (Katz and Solomon, 1958; Brown and Kosterlitz, 1964; Gottschalk, Mayerson and Gottlieb, 1967). Gottschalk et al. found that

in brief therapy, younger clients were more likely to drop out, while Brown and Kosterlitz found that in long-term treatment, clients younger than 30 or older than 39 were more likely to be lost. Four of the studies reviewed by Baekeland and Lundwall (1975) found that females are more likely to drop out of therapy than are males.

There is some question about the relationship between socio-economic status and dropping out. Baekeland and Lundwall (1975) found that lower socioeconomic status clients were more apt to drop out than were higher socioeconomic status clients in 16 of the 18 studies they reviewed. However, they attributed this pattern to the psychoanalytic orientation of the clinics involved. They found no study indicating a relationship between social class and duration of treatment in a setting in which a non-psychoanalytical therapy was employed.

The relationship between the diagnosis and drop-out rates is not clear. Half of the studies reviewed by Baekeland and Lundwall (1975) found no relationship, while the other half implicated four diagnoses: low levels of anxiety or depression, paranoid symptoms, sociopathic features and alcoholism. This is not surprising, since it is probable that it is the need for relief from anxiety and/or depression which most frequently brings clients into therapy; paranoid clients are likely to distrust the therapist; sociopaths are usually forced into treatment (e.g. by court order); and alcoholics are apt to deny their problem, to distrust authority figures and to have some somatic illness.

CHAPTER III

HYPOTHESES

Although this was primarily an exploratory study, 12 general hypotheses concerning elderly clients in psychotherapy were developed before the data were collected. On the basis of each hypothesis, one or more specific predictions were made about what data would be found in the case records of the subjects in this study if the hypothesis were correct. In part, this was done to focus the research on certain issues and, in part, it was done to test several proposals and/or assumptions which have been made by researchers or clinicians. These hypotheses, the predictions based upon them and the rationale for their development were as follows:

Hypothesis 1. More referrals would be made by social service agencies than by relatives or medical professionals.

Prediction 1a. Subjects would have been referred more often by social service agencies than by relatives.

Prediction 1b. Subjects would have been referred more often by social service agencies than by medical professionals.

If the relatives of elders share the generally negative impression that most of the aged have concerning mental health services, they are unlikely to refer them for treatment of anything short of gross impairment. It is also probable that physicians tend to rely upon medical types of intervention to treat psychiatric problems, rather than making referrals for mental health services, particularly when the

patient is elderly. Higher frequencies of referral are more likely from social workers in social service departments of acute care medical hospitals who coordinate the discharge of patients experiencing emotional and physical problems. Another major source of referrals is likely to be social service and Visiting Nurse Association personnel (e.g. chore service workers and home health aides) who come into frequent contact with the elderly, who are likely to observe emotional disturbances and/or unusual behavior and who are trained to act upon such observations.

Hypothesis 2. The frequencies of the reasons given for referrals would differ depending upon whether the clients reside in communities or in institutions such as nursing homes.

Prediction 2a. Subjects who resided in communities would have been referred more often for emotional problems than for management difficulties or concern about their capacity for independent living.

Prediction 2b. Subjects who resided in institutions would have been referred more often for disruptive behavior than for emotional problems.

Prediction 2c. Subjects who resided in institutions would have been referred for management difficulties more often than subjects who resided in communities.

There is not much information currently available in the scientific literature concerning the reasons elderly people are referred to community mental health centers. It is probable that the reasons for referral differ depending upon whether the client resides in the

community or in an institution, such as a nursing home. It is reasonable to assume that elderly residents of communities are referred for the full range of reasons that adults in general are referred, including a variety of emotional problems. This should contrast with the rather narrow number of reasons for which elders are referred to programs offering only a special service, such as crisis intervention or skills assessment. It should also contrast with the reasons for which residents of institutions are referred. In their cases, one would expect more referrals because of difficulties the institutions have in managing their disruptive behavior, as Patterson (1976) postulated.

Hypothesis 3. The frequencies of diagnoses assigned clients would differ depending upon whether they reside in communities or in institutions such as nursing homes.

Prediction 3a. Subjects who resided in institutions would have had a higher incidence of organic brain disorders, schizophrenia, paranoid disorders and psychotic disorders than subjects who resided in communities.

Prediction 3b. Subjects who resided in communities would have had a higher incidence of affective, adjustment and anxiety disorders than subjects who resided in institutions.

If there are significant differences in the reasons community residents and residents of institutions are referred, the diagnoses assigned these two populations are likely to differ. Nursing home residents should be more frequently diagnosed with organic brain disorders, schizophrenia and other disorders which give rise to

potentially disruptive behavior, such as non-compliance and aggression, while community residents should be more frequently diagnosed with affective disorders and anxiety-based disorders.

Hypothesis 4. The frequencies of complaints made by clients would differ depending upon whether they reside in communities or in institutions.

Prediction 4a. Complaints about poor health and somatic problems would have been made more frequently by subjects who resided in communities than by subjects who resided in institutions.

Prediction 4b. Complaints about inadequate financial resources, inadequate social interaction and transportation problems would have been made more frequently by subjects who resided in communities than by subjects who resided in institutions.

There is nothing in the current scientific literature about the complaints elders make during therapy. Considering the close relationship between poor physical health and stress among elders (Harel, Sollod and Bognar, 1982; Haug, Belgrave and Gratton, 1984; Preston and Mansfield, 1984), one would expect a high frequency of complaints concerning health problems among people experiencing some mental distress. Since people who reside in institutions are receiving medical treatment for their physical health problems, they are probably less likely to complain about them than residents of communities. Since low socio-economic level and social isolation correlate with mental illness (Bellin and Hardt, 1958; Warheit, Holzer and Schwab, 1973; Harrel, Sollod and Bognar, 1982), they are likely to appear as

complaints during therapy, particularly from community residents. These are less likely to be concerns for residents of institutions because an institutional setting provides ample opportunity for residents to socialize and their finances are handled by the social services staff.

Hypothesis 5. Clients residing in institutions would make more complaints about their institutional environment than than about other problems.

Prediction 5a. Subjects who resided in institutions made more complaints about a) loss of control, b) negative perception of residence, roommates or other residents, 3) lack of continuing ties with other people and 4) lack of social contact with preferred members of their own social network than they made about other things.

It is likely that most of the complaints made by residents of institutions would concern difficulties stemming from their institutional environment (e.g. negative perceptions of the residence, difficulties with roommates and/or other residents, lack of social contact with old friends and/or members of their families). It is less likely that they would complain of the problems of independent living (e.g. financial difficulties, somatic problems, transportation problems, lack of social engagement) which worry community residents.

Hypothesis 6. The frequencies of complaints made by men would be different from the frequencies of complaints made by women.

Prediction 6a. Male subjects would have complained more often than female subjects about role loss, stress associated with the loss of a spouse and physical limitations.

Prediction 6b. Female subjects would have complained more often than male subjects about lack of social involvement.

There have been no studies on the differences between elderly men and elderly women in therapy, although there have been studies on gender differences in the experiencing of stress. Although some similarities between the genders would be expected, it is probable that there is a greater concern among women than among men about lack of social involvement and lack of a confidante, considering the greater influence social factors are known to have on women's mental health (Elwell and Maltbie-Crannell, 1981; Windley and Scheidt, 1983). Women are also more likely to express feelings of uselessness, while among men there is a greater likelihood of concern about physical limitations, work role loss and stress associated with the loss of a spouse.

Hypothesis 7. The reasons therapy terminates for clients with organic brain disorders would be different from the reasons therapy terminates for clients with other symptoms.

Prediction 7a. Therapists would have terminated treatment of most subjects with organic brain disorders.

Prediction 7b. Most subjects with diagnoses other than organic brain disorders would have terminated their own treatment.

It is probable that clients with organic brain disorders would seldom drop out of therapy because of their desperate desire for a solution to their irreversible problems. It is more likely that their therapy would be terminated by their therapists.

Hypothesis 8. Clients who refer themselves would be less likely to

drop out of therapy than clients referred by someone else.

Prediction 8a. Subjects who referred themselves would have dropped out of therapy less frequently than those who were referred by others.

There is absolutely no information in the current scientific literature on the factors associated with elderly people who drop out of therapy. Some clinicians assume that elderly clients who refer themselves into therapy are more likely to continue than those clients who are referred by others. Such a pattern has been discovered by Baekeland and Lundwall (1975) among the general adult population. This hypothesis will test if that pattern also applies to elderly clients.

Hypothesis 9. Clients' persistence in therapy would be related to their diagnoses and psychiatric symptoms.

Prediction 9a. Subjects with paranoid ideation would have dropped out of therapy more frequently than other clients.

Prediction 9b. Subjects who were diagnosed as depressed would have dropped out of therapy less frequently than other subjects.

It is likely that persistence in therapy is also related to the client's psychiatric problems. For example, individuals with paranoid ideation would be expected to drop out of therapy more frequently than those who are depressed. While the former might be suspicious of their therapists, the latter would be expected to perceive therapy as a potential solution to their problems. In addition, Baekeland and Lundwall (1975) indicated that paranoid symptoms were risk factors related to drop-out from therapy by the general adult population.

Hypothesis 10. Clients who have access to support from their

family, friends and religion would be more likely to drop out of therapy than other clients.

Prediction 10a. Married subjects would have dropped out of therapy more frequently than widowed subjects.

Prediction 10b. Widowed subjects with living children would have dropped out of therapy more frequently than widowed subjects without living children.

Prediction 10c. Subjects who reported difficulty in their relationships with their spouse and/or child(ren) would have dropped out of therapy less frequently than those who did not report such difficulties.

Prediction 10d. Subjects who complained about loneliness and social inactivity would have dropped out of therapy more frequently than other subjects.

Prediction 10e. Subjects who reported a positive religious belief or religious activity would have dropped out of therapy more frequently than other subjects.

Several researchers have noted a correlation between family relationships and mental health. Palmore (1973) contended that elderly marriage partners provide emotional support for each other, thus minimizing the effects of mental disorders. Kohen (1983) found that widowed women tend to turn to their children for support in a time of crisis. Abrahams and Peterson (1978-79) demonstrated that elderly people who were experiencing disruptions in their relationships with their spouses and/or children were considerably more emotionally

disturbed than those with average relationships. Thus, clients with spouses or children who provide them with emotional support may be less likely to feel the need to continue professional therapy. On the other hand, clients having difficulties with their spouses or children may feel a stronger need to continue therapy.

Another factor which may be related to dropping out of therapy is the availability of social support from friends (e.g. age-peers, a confidante) which clients might perceive as preferable to therapy. Elwell and Maltbie-Crannell (1981) found that social involvement helps to mediate stress among elders. Several studies (Harel, Sollod and Bogнар, 1982; Beckman and Houser, 1982) have demonstrated a relationship between people's mental health and their social involvement or at least their perception of the adequacy of their social activity. More specifically, the relationship between having a confidante and mental health has been reported by Lowenthal and Berkman (1967) and Sparacino, (1978-79). It may be that clients with close friends may see the support they get from them as alternatives to their therapy.

In a similar manner, religious belief and activities may play a similar role. Those with strong beliefs and/or the fellowship of a religious organization and/or the guidance of the clergy may not feel as great a need for professional psychotherapy as those without pronounced religion.

Hypothesis 11. Community residents and residents of institutions would differ in their persistence in therapy.

Prediction 11a. Subjects who resided in communities would have

dropped out of therapy more frequently than subjects who resided in institutions.

It is also probable that there is a relationship between the reasons given for terminating therapy and the clients' residence. The passivity often associated with institutionalized individuals may well extend to their interactions in therapy. For example, clients residing in nursing homes who wish to terminate therapy may have difficulty specifying a reason, and may simply say they do not want to see the therapist or even refuse to interact with the therapist. In contrast, community residents are more likely to perceive themselves as in control of the therapeutic situation and may be more likely to say that they are terminating therapy because they can cope with their problems on their own. As a consequence of this perception of greater self-control and self-reliance, community residents would be expected to drop out of therapy at a greater rate than the residents of institutions.

Hypothesis 12. The factors identified as barriers to treatment which tend to prevent elderly people from entering psychotherapy in the first place would also be associated with elderly clients who begin treatment but then drop out.

Prediction 12a. The subjects formal education would have positively correlated with persistence in therapy.

Prediction 12b. Old-old subjects would have dropped out of therapy more frequently than young-old subjects.

Prediction 12c. Subjects in crisis would have dropped out of therapy less frequently than other subjects.

Prediction 12d. Among subjects who resided in communities, those who received care at a clinic would have dropped out of therapy more frequently than those who were treated on an outreach basis in their own homes.

Prediction 12e. Male subjects would have dropped out of therapy more frequently than female subjects.

The factors which have already been identified by Gaitz (1974), Knight (1978-79) and Levy (1981) as barriers to treatment which prevent elders from entering therapy in the first place may also be related to dropping out of therapy. If that is the case, it is probable that dropping out is correlated with less education, lower income, and increased age; that it is more typical of males than of females; and that it is less frequent among those receiving therapy in their own homes. Finally, Birren and Renner (1981) found that negative attitudes toward therapy were more prevalent among clients who had less formal education and were older.

CHAPTER IV

RESEARCH METHODS

Subjects

The subjects in this study were 298 clients over the age of 59 (age range = 60-98; mean age = 75.3; median age = 74.9) who received psychological services from the Senior Support Team of the Franklin County Mental Health Center in Greenfield, Massachusetts. The clients resided in cities and towns in Franklin and Hampshire Counties in living arrangements including both their own homes and such long-term care institutions as rest homes and nursing homes.

The majority of the subjects (88.3%) received individual counseling. For the purpose of this research, each of the 17 cases which involved couples counseling and the 12 cases involving family therapy were treated as single cases and information was collected on the person under whose name the case was opened. In most instances this was the person identified as experiencing the most stress. Eighteen of other cases involved clients who were relatives and whose presenting problems were somewhat interrelated, but who received treatment separately, usually from different therapists, and who either started or concluded therapy at different times. Four subjects received only case consultation services and two subjects received only psychological testing services.

Procedure

The Senior Support Team

The Senior Support Team was established in 1980 to provide traditional psychological services to the elderly residing in Franklin and Hampshire Counties. It was one of five teams of therapists within the Franklin County Mental Health Center. Like the other teams, it provided a wide range of services, including therapy for individuals, couples, groups and families. The offices of the Senior Support Team and two other programs providing services to elders (an elder day care center and a peer counseling program) were located in a building several blocks from the main mental health center. Therapy was provided at that site in or on an outreach basis in the client's residence.

The Senior Support Team consisted of an administrator and four master's degree level clinicians. From the the Team's beginning until December 1986, there were a total of two administrators, eight therapists and three nurses on the staff. All but two of the staff members were female. In addition, five graduate students (four master's degree candidates and one doctoral candidate) worked on the Team as interns for periods ranging in length from nine to 12 months. No more than two interns worked on the team at any time.

For the most part, the Team's services were free of cost to the clients. Some clients were billed through third party payments, usually Medicare and/or Medicaid. A few clients paid some money on a sliding fee scale, but in all cases these clients had received extended

treatment before being approached to share some of the expense.

Case Records

Information concerning the subjects was obtained from the case records kept by the therapists. A case record contained all information gathered about a client. This information included intake forms, a summary of any previous psychological treatment (if requested by the therapist), progress notes and a closing summary. There were two intake forms for each client. The first one, shown in Appendix A, was a detailed form completed by the client or the therapist which included information about the client's date of birth, current and/or previous occupation(s), income level, religion, marital status, living family members, co-residents, primary therapist and presenting symptoms. The therapist assigned diagnoses on Axes I, II and III of the DSM III after therapy began. Some members of the Team left the occupation section of the form blank or responded "retired" without including the client's former occupation. In addition, some therapists did not complete the income level section of the form, in an effort to make the client feel more comfortable.

The second intake form consisted of a narrative written by the therapist, based upon information gathered during the intake interview. The information included the date of the interview, the type of intake session (individual, family, group), background data (physical condition, medical problems, family constellation, living conditions), presenting problems, the client's history, the therapist's impression of the client's strengths and weaknesses and willingness to enter therapy

and a brief description of the prospective treatment plan. A copy of the guidelines used by all Senior Support Team members for the intake interview is shown in Appendix B.

Progress notes were kept on all therapy sessions conducted with a client. General information was provided on the location of the session, the problems or concerns presented by the client, action(s) taken by the therapist and, if applicable, a brief description of the therapist's interaction(s) with others (e.g. nursing home staff, relatives, elder day center staff) concerning the case. A copy of the progress notes form is shown in Appendix C.

The closing form, presented in Appendix D, consisted of a brief summary of the client's case, emphasizing the presenting problem, treatment provided and outcome. In addition, information was given on the date of the closing, the DSM III diagnoses and a judgment by the therapist as to whether the client's condition had improved, remained unchanged or worsened during the period of treatment.

Data Collection

Data for this study were collected on each client over the age 59 who received psychological treatment from the Senior Support Team from the time the Team was established in 1980 to December, 1986, provided the case was closed and therapy had terminated.

The data were collected by one of the therapists on the Senior Support Team. In accordance with Human Rights Regulations for the agency, only staff employed by the mental health center were permitted access to the case records and the records could not be removed from the

agency's offices. Each record was examined by the therapist in her office while she was alone. Interobserver agreement between the author and the therapist who collected the data was 92.4%, calculated by the following formula: $\text{agrees} / (\text{agrees} + \text{disagrees}) \times 100$.

Data Collection Forms

The data collected from the case records were recorded on the data collection forms shown in Appendix E and Appendix F. Most of the information recorded on the form shown in Appendix E was gathered from the intake forms. The information recorded on the form shown in Appendix F was gathered from the progress notes and the closing summary.

CHAPTER V

RESULTS AND DISCUSSION

Referral

Sources of Referrals

Hypothesis 1. The first hypothesis was that more referrals would be made by social service agencies than by relatives or medical professionals. Two specific predictions were based upon this hypothesis. The first was that subjects would have been referred more often by social service agencies than by relatives (Prediction 1a). The second was that subjects would have been referred more often by social service agencies than by medical professionals (Prediction 1b).

A summary of the data concerning the sources of the referrals for the subjects in this study is presented in Table G-1 in Appendix G. The greatest percentage of referrals came from social service personnel at nursing homes. A substantial majority of all subjects were referred by social service workers or agencies. On the other hand, very few subjects were referred by their relatives and only 14.1% of the referrals came from physicians and nurses combined. These percentages clearly supported both predictions.

Several patterns became evident when the subjects were separated according to residence. Almost two thirds of the clients who resided in institutions were referred by social service workers (nursing home social service personnel and social workers at acute care hospitals, who

had recommended therapy before the clients were placed in nursing homes). Nurses made the second highest percentage of referrals, possibly because most rest homes and small, private nursing homes do not have a social service staff. No institutionalized clients were referred by members of their family. These findings also supported both predictions.

Social service workers also played an important role in the referral of community-residing clients. A majority of the community residents were referred by social service personnel and agencies of various types. Much smaller percentages of community residents were referred by physicians and family members. In addition to supporting the predictions, these percentages supported a previous discovery by Wasson et al. (1984) that elderly people who receive in-home services are more likely to have their problems discovered and addressed by their in-home care providers than by members of their family or by physicians.

It is probable that most of the difference between the sources of referrals of community residents and residents of institutions was the result of which people had the greatest amount of contact with the client. Community residents probably had more contact with in-home service workers, senior service agencies, and their relatives. Residents of institutions probably had more contact with the social workers and nurses at the institutions.

A single sample proportion test was used to compare the rate of referrals from social service workers (social workers at acute care hospitals, in-home service personnel, senior service agencies,

protective service agencies, and social workers at nursing homes) to the rate of referral from relatives. When the test was applied to all subjects, the difference was found to be significant, $\underline{Z} = 11.00$, $p < .001$. When the test was applied separately to institutionalized clients, the difference was again found to be significant $\underline{Z} = 8.19$, $p < .001$. When the test was applied to community residents, the difference was again found to be significant, $\underline{Z} = 7.28$, $p < .001$. These results supported Prediction 1a.

The lack of referrals from relatives is disturbing. Reifler et al. (1981) pointed out that family members are the most effective at recognizing mental illness in their relatives and other studies (Ruffin and Urquhart, 1980; Knight et al., 1982) have reported that families are often the source of referrals. The services provided by the programs in these cited studies, however, were limited to assessment of cognitively and physically impaired elders and coordination of auxillary services for them in order to maintain independent functioning. This study, on the other hand, concerned a center offering elders a wide range of mental health services. The finding in this study of a limited number of referrals from relatives may indicate that family members were reluctant to recommend to their relatives that they need mental health services. There are several possible explanations for that pattern. Families may have feared that suggesting psychotherapy would upset their elderly relatives. Relatives may have had negative attitudes toward psychological treatment, as Gaitz (1974) suggested. Relatives may have been aware of problems, but were not sufficiently bothered by them to

suggest or seek professional help. Relatives also may have been less aware than social service agencies of the availability of mental health services. An alternative explanation is that social workers who come in contact with the elderly may be a bit overzealous and put their clients in contact with many services, including mental health services. Additional research is needed before we can fully understand the reasons for the unfortunate pattern observed.

A single sample proportion test was used to compare the rate of referrals from social service workers to the rate of referral from medical personnel (physicians, nurses at nursing homes, and an X-ray technician). When this test was applied to all subjects, the difference was found to be significant, $\underline{z} = 8.39$, $p < .001$. When this test was applied separately to institutionalized clients, the difference was again found to be significant, $\underline{z} = 4.58$, $p < .001$. When the test was applied to community residents, the difference was again found to be significant, $\underline{z} = 7.10$, $p < .001$. These results supported Prediction 1b.

The limited number of referrals by physicians is particularly regrettable, since they are frequently the first people approached when help is needed (Gurin, Veroff and Feld, 1960). Nonetheless, the findings of this study replicate previous discoveries by Kucharski, White and Schratz (1979) and by Lebowitz (1987) concerning the infrequency of referrals by physicians.

Self-referral. A relatively large percentage of the total subject population, most of them community residents, referred themselves for

mental health services. This pattern contradicted earlier reports of low percentages (2%-4%) by numerous investigators (Raskind et al., 1976; Ruffin and Urquhart, 1980; Riefler, Cox and Hanley, 1981; Riefler et al., 1982), but it is similar to the larger percentages reported by Winogron and Mirassou (1983).

The differences may be the result of differences between the type of program studied. All of the programs reporting low rates of self-referral were oriented toward such limited services as the assessment of functional skills and brief intervention when it seemed possible to maintain the client in the community. On the other hand, the programs upon which both this study and the Winogron and Mirassou study were based, offered a wide range of traditional mental health services. It is interesting to note that when elders were offered a full range of mental health services, instead of a few limited services, they made use of them, but their relatives were less likely to refer them. This pattern certainly deserves further study.

The vast majority of self-referrals were made by community residents, a finding which is not surprising considering the condition of much of the institutionalized population.

It is also noteworthy that the referrals came from a wide variety of sources. The extensive range suggests a broad base of familiarity with the program in the surrounding community, which, to some degree, increases the reliability of the findings of this study.

Reasons for Referrals

Hypothesis 2. The second hypothesis was that the frequencies of the

reasons for the referrals would differ depending upon whether the clients reside in communities or in institutions such as nursing homes. Three specific predictions were developed from this hypothesis.

Prediction 2a was that subjects who resided in communities would have been referred more frequently for emotional problems than for management difficulties or concern about their capacity for independent living. A summary of the data concerning the primary reasons clients were referred to the mental health center can be found in Table G-2. A secondary reason was given for the referral of 36% of the subjects. Those secondary reasons are summarized in Table G-3. As can be seen in Table G-2, the single most frequent reason for the referral of community residents was depression. The emotional problems (depression, adjustment problems, anxiety, alcoholism, loneliness and isolation) were the primary reasons for 43.8% of the referrals of community residents. Management problems, on the other hand, accounted for very few of the referrals of that population. The combined referrals for management problems, concern about the ability of the client to live independently and unusual behavior were only 21.9% of the referrals of community residents. When a single sample proportion test was used to compare the rate of referrals for emotional problems (depression, adjustment problems, anxiety, and isolation) to the rate of referrals for management problems (management problems, unusual behavior, and concern about ability to live independently) among community-residing subjects, the difference was found to be significant, $z = 3.49$, $p < .001$. This evidence supported Prediction 2a.

Prediction 2b was that subjects who resided in institutions would have been referred more often for disruptive behavior than for emotional problems. As can be seen in Table G-2, management problems were the most frequent reason for the referral of institutionalized subjects, but depression was the second most common reason for the referrals of that population. A single sample proportion test comparing the rate of referral for management problems and unusual behavior combined to the rate of referral for emotional problems (depression, adjustment problems, anxiety, alcoholism, loneliness and isolation) among institutionalized subjects demonstrated that the differences were not significant $Z = .93$, $p > .05$. Clearly the data did not support Prediction 2b.

This finding has implications for the planning of mental health services for the elderly. It is commonly assumed that if mental health services are made available to institutionalized elderly, most referrals would be for management problems and that few will be for the emotional problems traditionally associated with the general adult public. In part, this seems to be based upon the false assumption that the mental deterioration of most institutionalized elders is so severe that emotional problems are no longer a significant factor in their lives. It is also based upon the somewhat cynical assumption that the staff of institutions are more likely to refer elders for help when their disruptive behaviors interfere with the routine of the institution than when they need help with emotional problems. This was the view projected in Patterson's review (1976) of community mental health

clinics and was one foundation for his recommendation for increased in-service training for nursing home staff rather than for increasing the availability of more complete psychological services for, and consultations about, the elderly patients themselves. The evidence in this study undermined both these assumptions. When offered the opportunity for a full range of mental health services, institutionalized elders were almost as likely to be referred for emotional problems as for disruptive behavior.

Prediction 2c was that subjects who resided in institutions would have been referred for management problems more often than subjects who resided in communities. Management problems were, by far, the single greatest reason for the referral of institutionalized clients, while they were considerably less frequent among community residents. A two sample difference of proportion test was used to compare the rate of referral for management problems and unusual behavior combined among clients residing in institutions to the rate of referral for management problems and unusual behavior combined among community residents. The test demonstrated that the difference was significant, $Z = 4.43$, $p < .001$. The evidence supported the prediction.

Several other points should be made concerning the data on the reasons for referral.

Depression. Depression was the predominant reason for referral. Not only was it the primary reason in almost a third of the cases (see Table G-2), it was the secondary reason in 16% of the remaining cases (see Table G-3). It was the most frequent reason for referring

community residents and the second most frequent reason for referring institutionalized subjects. This finding indicated that depression is one of the biggest mental health problems for elders. Unfortunately, depression is often used as a catch-all category which is applied by people who are not psychotherapists to elderly people with a variety of emotional problems. The term is often used without any precise criteria (Blazer and Williams, 1980), making the reliability of this finding somewhat limited.

Family conflict. Family conflict also was a major primary and secondary reason for referral (See Tables G-2 and G-3). It was more of an issue among community residents than it was among institutionalized clients. It was the single most important reason that clients referred themselves, although it was a major reason for referrals from several other sources, particularly elder day centers, in-home service personnel, and senior service agencies.

Crisis. A summary of the data concerning subjects who reported that they were experiencing a crisis during the intake session and the first ten therapy sessions is presented in Table G-4. A feeling of urgency, extreme anxiety and/or a sense that the situation is unbearable appears to play a major role in prompting referrals to the mental health center. Slightly more than half of the clients were in a state of crisis at some point during the in-take session or the first ten therapy sessions. Slightly more than a quarter were in crisis at the time of intake. Crisis was most frequent at the time of intake among the institutionalized clients. On the other hand, transfer clients were

more likely to experience a crisis during the course of their treatment and it appeared likely that it was related to the change in residence. Whether the crises were one of the causes of their institutionalization or were the result of the institutionalization process is not clear from the data. When crisis was cross referenced with source of referral, it was found that crisis was more frequent among clients who were referred by themselves (61.8%), by elder day programs (62.5%), by nurses (63.2%), by protective services (66.7%), by mental health agencies (71.4%) and by foster care programs (100%) than it was among those referred by all other sources combined (46.9%).

These findings concerning the frequency of crisis situations supported the findings of previous studies (Raskind, 1976; Knight, Reinhart and Field, 1982) which reported that clients referred to mental health services were frequently in a state of crisis.

Physical dysfunction. Unlike several previous studies (Ruffin and Urquhart, 1980; Winogron and Mirassou, 1983; Reifler et al. 1982) which described referral patterns in mental health programs for the elderly, this study did not find a high frequency of referral for physical dysfunction, cognitive impairment, and medical problems. Once again, the difference between the finding in this study and those of previous studies could be attributed to the breadth of the services available. The previous studies cited concerned programs which were more oriented toward short-term assessment and crisis intervention, while this study concerned a program which offered a wide range of psychological services. Approximately a third of the subjects in this study were

residents of institutions who were already under the care of medical professionals and were unlikely to be referred for physical problems. Finally, the Senior Support Team received referrals from a wide variety of sources, many of whom would not be expected to refer elders with physical impairments to a mental health center.

Correlation of reasons for referrals with sources of referrals.

Table G-5 presents a cross-tabulation of the reasons for referrals and the sources of referrals. Self-referrals were primarily for family conflicts and depression. Relatives most often made referrals because of depression and management problems. In-home service personnel most often made referrals because of depression and made few referrals because of management problems. Physicians most frequently referred clients for depression and other emotion-based problems. In fact only a fifth of the referrals by physicians involved a reason other than an emotional problem. Referrals for family conflict most often came from elder day centers and in-home services, rather than from the families themselves. Finally, as one would expect, social workers in nursing homes most frequently referred clients for management problems.

Diagnoses

A summary of the data concerning the diagnoses assigned the subjects in this study can be found in Table G-6. The subjects were classified into 14 DSM diagnostic categories on Axis I, but the distribution was far from even. Eighty percent of the clients were classified into only

five categories: adjustment disorders, affective disorders, organic brain disorders, conditions not attributable to a mental disorder, and diagnosis deferred. This concentration was in keeping with Pfeiffer and Busse's (1973) report that older people have been found to manifest all of the psychiatric disorders observed in younger populations, but that the majority of the disturbances among the elderly tend to fall into a relatively small number of categories.

Adjustment disorder. Adjustment disorder was the most frequently assigned diagnosis. The subjects were assigned six different subcategories of adjustment disorders: with mixed emotional features (36%), with depressed mood (32%), with disturbance of emotions and conduct (12.8%), with anxious mood (6.8%), with atypical features (6.8%) and disturbance of conduct (.9%). Eight and a half percent of the adjustment disorders could not be subcategorized either because of incomplete diagnoses on the part of the therapist or because of the reclassification of clients with DSM II classifications to DSM III classifications.

Affective disorders. Only 12.8% of the total subject population was diagnosed with an affective disorder, the specific types being major depression (55%), dysthymic disorder (26%), bipolar disorder (13%), and major depression with psychotic features (5%).

This low frequency of affective disorders and the relatively high frequency of adjustment disorders corresponds with an observation made by Blazer and Williams (1980) about depressions among the elderly. They found that only 3.7% of their sample of non-institutionalized, elderly

people in general had depressions which met the DSM III definition of an affective disorder. The finding in this study that 16.1% of the clients in a community mental health center have an adjustment disorder marked by depression supported Blazer and Williams report of a prevalence rate of 12.8% among the general, non-institutionalized elderly population for depression which did not meet the requirements of an affective disorder.

Ten percent of the clients diagnosed with an affective disorder exhibited psychotic features. These people were evenly divided into those with major depressions and those with a bipolar disorder.

Twenty-three percent of the subjects were diagnosed with a condition which could be characterized as purely depressive in nature. Of these 30.4% were diagnosed with major depression, 14.5% were diagnosed with dysthymic disorder and 55% were diagnosed with adjustment disorder with depressed mood. The percentage of subjects diagnosed as depressed was approximately a third less than than the percentage of subjects referred for depression (see Table G-2). This discrepancy supported the contention by Blazer and Williams (1980) that a variety of psychological problems of elders are perceived as depression by people who are not psychotherapists.

Organic brain disorders. Of the total subject population, 15.4% were diagnosed with organic brain disorders, 11.1% on Axis I and 4.3% on Axis III. As one would expect, this diagnosis was considerably more frequent among institutionalized clients and transfer clients than among community-residing clients. The 15.4% figure is much higher than the

generally accepted (Kay and Bergmann, 1980) rate of 5% to 8% among people over the age of 59. To some extent this was due to the fact that the subjects in this study were clients at a mental health center, rather than a sample of the general elderly population. Another possible factor may have been the advanced age of the institutionalized subjects (mean age = 77.4 years). As Kay and Bergmann (1980) pointed out, the rate of organic brain disorder increases with age, reaching 20% at age 80.

Personality disorders. A personality disorder was diagnosed in 14.4% of all subjects on either Axis I (4.4%) or Axis II (10.5%). Ten different personality disorders were found, the most frequent being the passive-aggressive type (30.2%), followed by atypical (14%), compulsive (11.6%), dependent (11.6%), avoidant (9.3%), borderline (9.3%), schizoid (4.7%), paranoid (4.7%), narcissistic (2.3%) and antisocial (2.3%). Personality disorders were almost equally frequent among community residents and institutionalized clients. However, a passive-aggressive diagnosis was more frequent among the community residents (76.9%) than among the residents of institutions (23.1%).

Schizophrenia. Six percent of the total subject population was diagnosed as schizophrenic, 4.7% on Axis I and 1.4% on Axis II. There was not much difference in frequency between community residents and the residents of institutions. The high frequency of schizophrenia is probably attributable to a commitment on the part of the mental health center to serve clients deinstitutionalized from a state hospital located 20 miles from the center. The combination of the rates of

schizophrenia (6%) and psychotic disorders not elsewhere classified (1.3%) supported Passamanick's (1962) contention that the rate of psychosis among the elderly is about 4%.

Alcoholism. Only 1.3% of the subjects were diagnosed on Axis I as having a substance use disorder. The frequency was about the same in all residential groups. Although the percentage of elderly alcoholics provided mental health services on an outpatient basis is not known, the rate of alcohol related problems among the elderly has been estimated at anywhere from 1% to 24% (Woods, 1987). Given the increased interest in recent years in alcohol abuse and the elderly, the percentage among the clients served by the agency studied was low.

Conditions not attributable to a mental disorder. Conditions not attributable to a mental disorder were diagnosed for 8.8% of the subjects. This was most frequent among clients who transferred into or out of an institution during the course of their treatment. Six different subcategories of V-codes were assigned: phase of life problem (52%), uncomplicated bereavement (26%), marital problem (11%), adult anti-social behavior (3.7%), other specified family circumstances (3.7%), and other interpersonal problems (3.7%).

Anxiety disorders. Few subjects were diagnosed with an anxiety disorder, and most of these were community residents. Five subcategories were assigned: agoraphobia (35.7%), generalized anxiety disorder (28.5%), panic disorder (14%), social phobia (14%), and atypical anxiety disorder (7%).

Both V-codes and anxiety disorders could be considered transient

situational disorders. The finding that 12.8% of the subjects were assigned to these two diagnostic categories combined tended to support Redick and Taube's report (1980) that 11.4% of elderly admissions to outpatient psychiatric services were for transient situational disorders.

Paraphilias. Very few subjects were diagnosed with paraphilia. Two of the cases involved exhibitionism, while the third was diagnosed as pedophilia. Two of the cases were court ordered, and, as is usual in such cases, these clients received few treatment sessions, since their only motivation was the desire to avoid incarceration, as was noted in their case records.

Deferred diagnoses. Diagnosis was deferred for 8.4% of the subjects. In most cases this probably was the consequence of the client not attending enough sessions to permit diagnosis, since 68% of the subjects in this category attended fewer than 10 sessions.

Paranoid ideation. About a quarter of the subjects exhibited paranoid ideation. When paranoid ideation was cross-tabulated with diagnosis, it was not surprising to find that a considerable percentage of the clients diagnosed with psychoses (schizophrenia, 64.3%; paranoid disorders, 100%; Psychotic disorders, 25%) expressed paranoid thoughts. People with organic brain disorder also frequently (39.4%) exhibited paranoid tendencies. Paranoid thoughts were also far more frequent among transfer clients (53.3%) than among either institutionalized (28%) or community-residing clients (16.8%). A chi-square test for homogeneity indicated that the differences between the frequency of this

symptom among the three residential groups was significant, $\chi^2(2, n = 298) = 15.46, p < .001$. Whether this was the result of fears that arise during the transfer process or whether the paranoia was one of the contributing causes of the transfer is not clear from the data.

Hypothesis 3. The third hypothesis was that the frequencies of the diagnoses assigned clients would differ depending upon whether they reside in communities or in institutions such as nursing homes. This hypothesis was the basis of two predictions.

Prediction 3a was that subjects who resided in institutions would have had a higher incidence of organic brain disorders, schizophrenia, paranoid disorders and psychotic disorders than subjects who resided in communities. A fifth of the institutionalized clients were diagnosed with organic brain disorders, while only 5.5% of the community residents were so diagnosed. The difference was almost as great in the frequency of schizophrenia which afflicted twice as many residents of institutions as community residents. Even when paranoid disorders and psychotic disorders were added to organic brain disorders and schizophrenia, the totals were 31% of the institutionalized clients compared to 11.5% of the community residents. A two sample difference of proportion test applied to subjects diagnosed with organic brain disorder, schizophrenia, paranoid disorder and psychotic disorder indicated that the difference between community residents and residents of institutions was significant, $z = 3.76, p < .001$. This evidence supported Prediction 3a.

There are two possible explanations for the high frequency of these

disorders among nursing home residents in this study, one of which is probably generalized to all such populations, the other of which may be peculiar to this specific population. The first is that each of these disorders is likely to result in the kind of nuisance behavior which will cause nursing home personnel to refer the person for management problems. The second is that several nursing homes in the area served by the Senior Support Team had residents who were deinstitutionalized from a large state mental hospital in 1979.

Prediction 3b was that subjects who resided in communities would have had a higher incidence of affective, adjustment and anxiety disorders than subjects who resided in institutions. Although the frequency of adjustment disorders was higher among community residents than among residents of institutions, the distinction was not substantial. Anxiety disorders were six times more frequent among community residents than among residents of institutions, but the total number of clients involved was small. The frequencies actually ran counter to Prediction 3b in the case of affective disorders. A two sample difference of proportion test on community residents and residents of institutions demonstrated that there was no significant difference between them in the incidence of these three disorders, $Z = 4.32$, $p > .05$. Prediction 3b was not supported by this evidence.

The finding concerning Prediction 3b was parallel to and related to the finding relative to Prediction 2b concerning reasons for referrals. Not only were institutionalized clients as likely as community residents to be referred for emotional problems, they were just as likely to be

diagnosed as having emotion-based problems.

Complaints

The data concerning complaints made by clients while they were in therapy are summarized in Table G-7. Obviously clients who attended a large number of therapy sessions had far more time to make complaints. In order to prevent this from influencing the results of the study, only those complaints made during the intake session and the first nine therapy sessions were included in this analysis. In addition, several clients were completely or almost completely non-verbal. Because they expressed no complaints, they were deleted from the pool of subjects for analysis concerning this particular topic. Finally, since it can be reasonably assumed that clients are unlikely to make all their complaints during the first or second therapy session, only those clients who had attended at least three sessions were considered. As the result of these last two considerations, data from only 241 (80.9%) of the subjects were analyzed concerning complaints.

Three types of complaint predominated and were reported by nearly half of the population analyzed.

Difficulty with spouse and/or children. The most common complaints concerned difficulties with spouse and/or children. This complaint was far more frequently made by community residents and transfer clients than by institutionalized clients. A chi-square test for homogeneity indicated that these differences were significant, $\chi^2(2, n = 241) = 24$,

$p < .001$. Presumably this pattern occurred because community residents and transfer clients were more frequently involved with their families and relied upon them more, and, consequently, had more occasions to find fault with them.

Poor physical health. The second most frequent category of complaint was poor physical health . It should be noted that the data concerned the clients statements about their own subjective perceptions of their physical health, rather than an objective evaluation of their condition. Nevertheless, the high frequency of complaints about poor health from these people who were receiving mental health services did tend to support the close relationship between physical health and mental health found in previous studies (Bergmann, 1970; Harel et al., 1982; Haug et al., 1984).

Once again, these complaints were made more frequently by transfer clients and community residents than by institutionalized clients. A chi-square test for homogeneity demonstrated that these differences were significant, $\chi^2(2, n = 241) = 8.82, p < .01$.

Several factors may have contributed to that result. Many clients who were community residents may actually have been suffering from physical ailments, particularly if there is a close relationship between physical health and mental health. Probably most of the clients who moved into nursing homes during their treatment believed that their poor physical health was the reason for the move. On the other hand, most of the clients who were already residents of institutions when their therapy began were receiving constant professional attention for

their physical ailments and were in close proximity to many people whose physical condition was far worse than their own. Under those circumstances, it was not surprising that they were less vocal about their own physical health problems.

Lack of control. The feeling that things were out of control was more often expressed by transfer clients and institutionalized clients than by community residents, although a chi-square test for homogeneity did not show this to be significant, $\chi^2(2, n = 241) = .56, p < .755$. The fact that the percentages were somewhat higher among transfer and institutionalized clients is not surprising since they were not in control of their environments and consequently may have felt less control over their own lives. Probably the feeling that things were out of control was a major factor which induced these people to enter therapy.

Three additional types of complaint were made by about a third of the subjects.

Physical limitations. Not surprisingly, complaints about physical limitations were more common among institutionalized clients and transfer clients (whose environments were extremely limited or were becoming so) than among community residents. However, a chi-square test for homogeneity did not indicate that this difference was significant, $\chi^2(2, n = 241) = .395, p < .82$.

Loneliness. Loneliness was reported more frequently by transfer clients and community residents than by institutionalized clients. A chi-square test for homogeneity indicated that these differences were

significant, $\chi^2(2, n = 241) = 9.39, p < .01$. The lower rate of complaints of loneliness by nursing home residents may have reflected the fact that the congregation of people in nursing homes and rest homes tended to reduce feelings of loneliness. Another factor may have been that institutions had a higher concentration of people demented by brain disorders. Those people would have been unlikely to complain about loneliness.

Aches and pains. The rate of complaints about aches and pains was approximately uniform across all residential categories. The frequency and broad distribution of this complaint, along with those concerning physical limitations and poor health, supported the numerous studies (Raymond, Michals and Steer, 1980; Harel, Sollod, and Bogner, 1982; Preston and Mansfield, 1984; Haug, Belgrave and Gratton, 1984) which indicate that impairments to health are severe stressors. The frequency of reports of aches and pains illustrated that these sensations were ever present concerns for those with physical problems.

Abandoned by family. Complaints about being abandoned by their families were far more frequent among transfer and institutionalized clients than among community residents. A chi-square test for homogeneity indicated that these differences were significant, $\chi^2(2, n = 241) = 16.17, p < .001$. Again, these findings were to be expected. It seems reasonable to assume that when people moved into an institution they felt that their families had let them down and had not provided them with the help they needed in order to stay out of an institution.

Hypothesis 4. The fourth hypothesis was that the frequencies of

complaints made by clients would differ depending upon whether they reside in communities or in institutions. Two specific predictions were based upon this hypothesis.

Prediction 4a was that complaints about poor health and somatic problems would have been made more frequently by subjects who resided in communities than by subjects who resided in institutions. As can be seen in Table G-7, poor health was somewhat more frequently reported by community residents than institutionalized clients, there was not much difference between the residential groups in respect to complaints about aches and pains, and residents of institutions complained somewhat more than community residents about physical limitations. A chi-square test for homogeneity indicated that there was no significant difference between these two residential groups in the frequency of complaints about poor health, physical limitations and aches and pains, $\chi^2(1, n=241) = .484, p < .487$. The prediction is not supported by the evidence.

The data indicated that physical limitations and discomfort were major concerns for elderly mental health clients, regardless of their residential situation. Residents of nursing homes who, as was noted earlier, complained less often than community residents about poor health, complained somewhat more frequently than community residents about physical limitations and aches and pains. Perhaps this was the result of the patient role often played by residents of nursing homes (Kart, Metress and Metress, 1978). It is common for such facilities to emphasize the residents illness by referring to residents as patients

and having the staff wear medical uniforms. The patient role is played out by residents who complain of discomforts which are relieved by medication given at regularly scheduled intervals.

Prediction 4b was that complaints about inadequate financial resources, inadequate social interaction and transportation problems would have been made more frequently by subjects who resided in communities than by subjects who resided in institutions. As can be seen in Table G-7, there was very little difference between community residents and the residents of institutions in the frequency of complaints about poor social life, lack of continuing ties with others, and financial problems. A few community residents made complaints about transportation problems, while residents of institutions made none. A chi-square test for homogeneity on complaints about financial limitations, poor social life, lack of continuing ties with others, and lack of transportation indicated that the differences between community-resident clients and institutionalized clients were not significant $\chi^2(1, n = 225) = 2.71, p < .099$. The prediction was not supported by the evidence.

The numerous complaints about poor social life made by community residents were expected, but their frequency among institutionalized people was unexpected. There was a difference between this pattern and the finding concerning reports of loneliness. Although the institutionalized clients were less likely than other clients to report being lonely, they were just as likely as others to report having a poor social life. While these two types of complaints may seem to be

related, they might differ in quality. Loneliness might imply not seeing others in general, while poor social life might imply not seeing specific people with whom socializing is desired.

The almost equal frequency of complaints about financial problems by community residents and residents of institutions may have been due to the fact that many nursing home residents had little access to personal money because almost all their income goes to cover their housing and medical expenses.

The nearly equal frequency of complaints about the lack of continuing ties to others among community residents and residents of institutions indicated that this is a problem for some people regardless of living arrangements.

Finally, it is worth noting that, with the exception of complaints about poor social life, the complaints listed in Prediction 4b were not frequently made by the subjects and, consequently, did not appear to be primary concerns or stresses experienced by psychologically maladjusted elders.

Hypothesis 5. The fifth hypothesis was that clients residing in institutions would make more complaints about their institutional environment than about other problems. This was the basis of the prediction that subjects who resided in institutions would have made more complaints about a) lack of control, b) negative perception of residence, roommates and other residents, c) lack of continuing ties with other people and d) lack of social contact with preferred members of the client's own social network than they would have made about other

things.

The evidence not only failed to support the hypothesis, it indicated a pattern opposite to that predicted. Among residents of institutions, the complaints listed in the prediction were outnumbered by other complaints. A T-test was used to compare the proportion of complaints listed in the prediction to all other complaints made by clients who resided in institutions. The difference between the means of the two sets of complaints was found to be significant, $T(240, n = 241) = 13.13$, $p < .001$.

That finding indicated that the concerns of residents of institutions covered a broad range and were not limited to those which resulted from their institutional environment. Residents of institutions complained frequently about their physical health problems (poor health, physical limitations, aches and pains), social isolation (loneliness, poor social life, lack of someone to talk to, lack of continuing ties, lack of contact with a preferred person) and poor family life (difficulty with spouse and/or children, loss of spouse, abandonment by family).

In fact, the general pattern of complaints from residents of institutions was not much different from that of community residents. There were a few notable differences. Community residents were more vocal about difficulties with their relatives and transportation problems; residents of institutions were more concerned about their cognitive losses, which was not surprising considering the difference between the two residential groups in the rate of organic brain

disorder. It is notable that residents of institutions recognised their cognitive limitations and were worried about them. Perhaps this resulted from the fact that those who still had some awareness of their own progressive deterioration were in close proximity to to others with advanced cases of organic brain disorder. In other respects, the complaints of the two residential groups were more notable for their similarities than for their differences.

Hypothesis 6. The sixth hypothesis is that the frequencies of complaints made by men would be different from the frequencies of the complaints made by women. Two predictions were based upon this hypothesis.

Prediction 6a was that male subjects would have complained more often than female subjects about role loss, stress associated with the loss of a spouse and physical limitations. Table G-8 presents a tabulation of complaints made by men and women as well as the results of chi-square tests on each of them. There were virtually no differences at all between men and women in respect to complaints about physical limitations and loss of spouse. On the other hand, twice as many men as women complained about the loss of their work role, a finding which a chi-square test indicated was significant, as Table G-8 notes.

These findings clearly indicated that both physical limitations and the loss of a spouse were equally stressful to men and women. The differences between men and women concerning complaints about loss of work role were expected. It is highly probable that few women in the age cohort in this study worked outside the home and, if they did, they

probably viewed their work as secondary to that of being housewife and mother. This pattern is likely to change over time as women currently working reach retirement age.

Prediction 6b was that female subjects would have complained more often than male subjects about a lack of social involvement. As can be seen in Table G-8, women made more complaints than did men about loneliness, poor social life, lack of someone to rely upon, lack of continuing ties with others and lack of contact with a preferred person. A chi-square test for homogeneity between men and women in respect to complaints about loneliness, poor social life, lack of someone to talk to, lack of someone to rely upon, lack of continuing ties with others and lack of contact with a preferred person indicated that the differences between the genders was significant, $\chi^2(1, n = 241) = 6.42$, $p < .01$. The evidence supported Prediction 6b. The higher rate of complaint from women than men concerning their lack of social participation tended to support Elwell and Maltbie-Crannell's work (1981) on the importance of social participation in mediating stress among older women.

Several other observations concerning gender can be made based upon the data. Women were twice as likely as men to complain about aches and pains, a difference which a chi-square test indicated was significant, as is noted in Table G-8. This may result from the pattern noted by Verbrugge (1987) that elderly men have more serious, life-threatening health problems, while elderly women have more numerous, milder health problems which are bothersome. Women complained more frequently than

men about being abandoned by their families, a finding which displayed a tendency toward significance. Women also more frequently complained about having no one to rely upon. These patterns may be a function of the fact that women are more frequently widowed than men and require more support and help. Finally, with the exception of loss of work role and loss of independence, none of the complaints which were included in this hypothesis were more frequently made by men than by women.

A summary of the data concerning complaints made by men and women who resided in communities and complaints made by men and women who resided in institutions is presented in Table G-9. Chi-square tests for homogeneity were run on all complaints made by each gender in each of these two residential categories. Only one significant difference was found. More community-resident women than community-resident men reported aches and pains, $\chi^2(1, n = 167) = 7.96, p < .005$.

Termination of Treatment

Reasons Therapy was Terminated

The data concerning the reasons why treatment terminated for the subjects in this study are summarized in Table G-10.

Twelve percent of the subjects died during therapy. Death was more frequent among institutionalized clients and transfer clients than community residents. This was not surprising because the mean age of the residents of institutions (77.4) was higher than that of the community residents (73.8) and the rate of organic brain disorders among

residents of institutions (20%) was much higher than that of the community residents (5.5%).

Almost twice as many terminations were initiated by clients themselves than by therapists. A surprisingly small percentage of the terminations were reported as mutually agreed upon by client and therapist. There was no simple explanation for this. It may have resulted from reluctance on the part of some therapists and/or clients to end treatment when a client was still experiencing some problem. Only 9% of the cases were terminated because the therapist believed that the client's situation had improved or that the problem had been resolved. When cases in which improvement was noted and in which termination was mutually agreed upon were added together, it was found that less than a fifth (18.7%) of the cases ended with the therapist stating that termination was appropriate.

Relationship Between Termination and Diagnosis

Community residents terminated their own therapy far more often than clients who resided in institutions or who moved into institutions during the course of their treatment. Therapists initiated the termination of treatment for half of the subjects who were living in institutions at the time therapy stopped, but they initiated less than a fifth of the terminations of community residents. To some extent, that pattern may have resulted from the higher rates of organic brain disorders and psychotic disorders among the residents of institutions.

Hypothesis 7. The seventh hypothesis was that the reasons therapy terminated for clients with organic brain disorders would be different

from the reasons therapy terminated for clients with other diagnoses. This generated the predictions that therapists would have terminated treatment of most subjects with organic brain disorders (Prediction 7a) and that most subjects with diagnoses other than organic brain disorders would have terminated their own treatment (Prediction 7b).

A cross-tabulation of the diagnoses assigned to clients and who initiated the termination of therapy is presented in Table G-11. The majority of clients with all but two diagnoses terminated their own therapy. On the other hand, a substantial majority of those with organic brain disorders had their therapy terminated by their therapist. Those with psychotic disorders had their therapy terminated in equal percentages by themselves, by their therapists, by a mutual agreement of themselves and their therapists, and on the recommendation of some other professional. A chi-square test for homogeneity in which the source of the termination of therapy was cross-tabulated with diagnoses indicated that the differences were significant in the predicted direction, $\chi^2(42, N = 298) = 75.84, p < .001$. These findings supported prediction 7a and supported prediction 7b relative to all diagnoses except psychotic disorders.

These results suggested either that clients with organic brain disorders were reluctant to leave treatment or that therapists believed that therapy was less appropriate for them than for other clients. Some support for the latter interpretation was found in the high percentage (63.6%) of organic brain disorder clients whose treatment was terminated by a therapist before the twentieth therapy session. That pattern

suggests that therapists were often not satisfied with the progress of therapeutic sessions with organic brain disorder clients, probably because the clients were not able to process information at the level expected by the therapist.

Persistence in Therapy

Definition of Drop-Out

One problem which had to be addressed before analysis could proceed on persistence in or drop-out from therapy was that there has been no general agreement among researchers as to how to define or measure drop-out. In their review article concerning studies on drop-out from therapy among the general adult population, Baekeland and Lundwall (1975) noted that there are at least two quite distinct definitions and measures. Some researchers (e.g. Straker, 1968) have used the tenth therapy session as the criterion, since some forms of brief therapy can be completed by that point. Thus they defined dropping-out as quitting before the tenth therapy session. Other researchers (e.g. Cartwright, 1955; Standal and van der Veen, 1957; Taylor, 1956) have used the twentieth therapy session as the criterion for persistence because some therapeutic methods require at least that many sessions. They considered anyone who quit before the twentieth therapy session to have dropped-out.

In order to make the results of this study valuable to the greatest number of researchers and clinicians, regardless of which criterion they

use, the subjects in this study were separated into four persistence groups, depending upon how many sessions they attended. Those in Group 1 attended no more than an intake session and two therapy sessions. Obviously, those clients received no significant amount of therapy before they dropped out. Those in Group 2 attended from three to nine therapy sessions. They probably received some help, but they dropped out before completing the ten sessions which are generally considered a minimum for even brief therapy. Those in Group 3 attended from 10 to 19 therapy sessions, during which they probably received significant treatment, but not enough to meet the criterion of some experts. Whether these subjects should be classified as drop-outs is debatable. Those in Group 4 attended 20 or more therapy sessions. Most experts would consider them to have persisted in their therapy.

Since dropping-out of therapy also involved the willingness of the clients themselves to continue or not to continue, those whose treatment was terminated by their therapist or with the mutual agreement of their therapist were removed from Groups 1, 2 and 3, as were those who died before their twentieth session. Since all subjects who attended at least 20 therapy sessions were considered persistent, all subjects who made that criterion were included in Group 4, regardless of how their treatment ultimately terminated.

Relationship to Self-Referral.

Hypothesis 8. The eighth hypothesis was that clients who referred themselves were less likely to drop out of therapy than clients referred by someone else. The prediction was that subjects who referred

themselves would have dropped out of therapy less frequently than those who were referred by others.

A summary of the data collected and analyzed relative to this hypothesis is presented in Table G-12. Even though 53.8% of the clients who referred themselves dropped out before a tenth session, a considerable 39.6% of the clients referred by others also dropped out before a tenth session. The pattern actually ran against the prediction when a larger number of therapy sessions was used as the criterion. While only 34.6% of the self-referred clients continued until at least the twentieth session, 50% of the clients referred by others made it to that point. A chi-square test for homogeneity demonstrated that there was no significant pattern in the distribution of self-referred subjects and subjects referred by others across the four persistence groups, $\chi^2(3, n = 210) = 2.08, p < .55$. Obviously this evidence did not support the hypothesis.

This finding conflicted with the results of earlier studies among the general adult population reviewed by Baekeland and Lundwall (1975) and contradicted an assumption which is rather widely believed by clinicians. On the other hand, it gave greater credence to Baekeland and Lundwall's contention that the relationship between self-referral and persistence observed in earlier studies with younger adults may have been the result of such intervening variables as socio-economic status and motivational factors.

Relationship to Diagnosis and Psychiatric Symptoms.

Hypothesis 9. The ninth hypothesis was that clients' persistence in

therapy would be related to their diagnoses and psychiatric symptoms. This generated two specific predictions.

Prediction 9a was that subjects with paranoid ideation would have dropped out of therapy more frequently than other subjects. A summary of the data collected and analyzed concerning this hypothesis is presented in Table G-12. That data indicated that clients with paranoid ideation tended to persist in treatment rather than to drop out, a pattern exactly opposite to that predicted. A third of those with paranoid symptoms dropped out before the tenth session, but 43.3% of those with no paranoid ideation dropped out by the tenth session. Three-fifths of the subjects with paranoid thoughts attended 20 or more sessions, while only 44.6% of the clients without that symptom returned for at least twenty sessions. A chi-square test for homogeneity indicated that the difference between the persistence patterns of paranoid and non-paranoid subjects was significant, $\chi^2(3, n = 208) = 8.1, p < .043$. The paranoid subjects in this study were significantly more persistent than other subjects.

This finding contradicted that of earlier studies reviewed by Baekeland and Lundwall (1975) which found a correlation between paranoia and drop-out from therapy by younger adults. Baekeland and Lundwall believed that the findings of those studies showed that adult clients with paranoid ideation were distrustful of their therapists. The findings in the present study indicated that elderly clients, on the other hand, may be able to overcome their misgivings and remain in treatment in an effort to sort out their thoughts and to determine if

they are valid. Part of the difference may have been due to a particular form of late-onset paranoid ideation which is relatively common among elders, particularly those who are socially withdrawn (Whitehead, 1979). Perhaps experiencing paranoid thoughts late in life, after years of keeping these suspicions in check, may have given the subjects a greater ability to question the validity of their fears.

Prediction 9b was that subjects diagnosed as depressed would have dropped out of therapy less frequently than other subjects. As can be seen in Table G-12, the percentages of depressed and non-depressed clients in each of the four persistence groups were almost identical. That pattern did not support Prediction 9b. Because depression is a major component in both affective and adjustment disorders, a chi-square test for homogeneity was done on the persistence patterns of subjects with those two disorders combined and subjects with all other diagnoses combined. That test indicated no significant difference between the persistence patterns of subjects with those two diagnoses and subjects with other diagnoses, $\chi^2(3, n = 210) = .8, p < .845$. That implied that there was no difference between the persistence patterns of depressed and non-depressed subjects. This result also provided no support for Prediction 9b.

Perhaps the lack of difference between the persistence rates of depressed and non-depressed subjects was the result of differences in persistence rates among the various diagnostic categories.

Distinct differences between persistence patterns were discovered among several diagnoses, as can be seen in the findings summarized in

Table G-13. Clients in several categories had a decided tendency to remain in therapy. A majority of the subjects with organic brain disorders, somatoform disorders, anxiety disorders, and affective disorders attended at least 20 sessions. Almost a majority of those with adjustment disorders and schizophrenia attended at least 20 therapy sessions. On the other hand, only 25% of those with V-codes and personality disorders attended 20 or more sessions. These patterns were not surprising. Clients assigned a V-code were probably involved in a transient situation which diminished during the course of treatment. Those with personality disorders probably had idiosyncratic styles of thinking and perceiving which fostered an externalized view of the problem situation and reduced motivation for change. Those with organic brain, somatoform, anxiety and affective disorders were probably suffering severe discomfort and were more motivated to continue treatment.

One factor which may have distinguished disorders which manifested a high drop-out rate from those with a low drop-out rate was the severity of the discomfort associated with the disorders. Affective, somatoform, anxiety and organic brain disorders usually result in severe discomfort, while adjustment disorder, V-codes and psychological factors affecting physical condition usually result in much less discomfort. A chi-square test for homogeneity indicated that there was a significant difference in the persistence patterns of subjects with the first three diagnoses combined and subjects with the second three diagnoses combined, $\chi^2(3, n = 161) = 12.92, p < .005$. This finding supported Baekeland and

Lundwall's (1975) observation that clients with diagnoses which result in lower levels of anxiety and depression tend to drop out of therapy. On the other hand, it indicated that the reason for the high rate of persistence was not the anxiety and depression per se, but the degree of discomfort the clients were experiencing.

Relationship to Support.

Hypothesis 10. The tenth hypothesis was that clients who have access to support from their family, friends and religion would be more likely to drop out of therapy than other clients. Five predictions were based upon this.

Prediction 10a was that married subjects would have dropped out of therapy more frequently than widowed subjects. The information analyzed relative to this hypothesis is summarized in Table G-14. Half of the married subjects and slightly over a third of widowed subjects dropped out of therapy before the tenth session. Slightly over a third of the married subjects and slightly over a half of the widowed subjects continued to at least the twentieth session. A chi-square test for homogeneity indicated that these modest differences were not significant, $\chi^2(3, \underline{n} = 163) = 6.16, p < .104$). In an effort to rule out the possibility that institutionalized subjects might be less reliant upon their spouses, the chi-square test was run a second time on only the community residents. That test again indicated that the difference was not significant, $\chi^2(3, \underline{n} = 115) = 2.27, p < .518$. This finding suggested that married clients were experiencing problems which could not be alleviated by their spouses or may even have stemmed from them.

Prediction 10b was that widowed subjects with living children would have dropped out of therapy more frequently than widowed subjects without living children. As Table G-14 indicates, there was only a modest difference between the percentage of widowed clients with living children and the percentage of widowed clients without children who dropped out before the tenth session. The difference between the percentages of those with living children and without living children who continued for at least twenty sessions was also small. Not surprisingly, a chi-square test for homogeneity found no significant difference between persistence patterns of these two groups, $\chi^2(3, \underline{n} = 103) = 4.02, p < .259$. This result did not support Prediction 10b.

In order to control for the possibility that institutionalized clients are less dependent upon their children, community-resident widows and widowers were analyzed (see Table G-14). When a chi-square test was run on these subjects, there was no significant difference between the persistence patterns of those with and without living children, $\chi^2(3, \underline{n} = 66) = 6.65, p < .08$. Even the proximity of the children did not seem to matter. A third chi-square test comparing community residents with children living within 20 miles to community residents without children living within 20 miles (see Table G-14) indicated no significant difference in their persistence patterns, $\chi^2(3, \underline{n} = 66) = 5.38, p < .146$.

These findings implied that Prediction 10b was unfounded and that once clients were in therapy, access to support from family members did not influence persistence. This may have been because relatives were

unable to reduce the need for professional help in dealing with psychological problems or it may have meant that the family members themselves were involved in the clients' problems.

Prediction 10c was that subjects who reported difficulty in their relationship with their spouse and/or child(ren) would have dropped out of therapy less frequently than other subjects who did not report such difficulties. Information concerning only clients who had a living spouse and/or child(ren) was included in the test of this prediction. As can be seen in the Table G-14, almost equal percentages of those reporting difficulties with their close relatives and those not reporting difficulties with their close relatives were in Group 3. The percentages are also quite close among those reporting difficulties and not reporting difficulties who made it to the twentieth session. Not surprisingly, a chi-square test for homogeneity found no significant differences between the persistence rates of these two groups, $\chi^2(3, n = 158) = 2.85, p < .415$. Prediction 10c was not supported by the evidence. This finding indicated that although family conflict may have been a stressor which caused subjects to enter therapy, once they were receiving treatment, it did not influence whether or not they dropped out.

Prediction 10d was that subjects who complained about loneliness and social inactivity would have dropped out of therapy less frequently than other subjects. In order to test that prediction, the subjects who complained during the intake session or first nine therapy sessions about poor social life and/or loneliness and isolation were separated

from those who did not make such complaints (see Table G-15). Over a half of those who did not complain about their social life dropped out before the tenth session, while only 29.4% of those who complained of a poor social life dropped out before the tenth session. Only two-fifths of those who did not complain about their social life persisted to the twentieth session, while a clear majority of those who complained about a poor social life persisted to the twentieth session. A chi-square test on the persistence patterns of these two populations demonstrated that the differences were significant, $\chi^2(3, n = 210) = 17.17$, $p < .001$). This evidence supported Prediction 10d and indicated that social inactivity was positively correlated with persistence in therapy. This evidence also supported the finding by Harel, Sollod and Bogнар (1982) that there is a positive relationship between mental health problems and perceived lack of social interaction and loneliness.

Prediction 10e was that subjects who reported a positive religious belief or religious activity would have dropped out of therapy more frequently than other subjects. In order to test the prediction, subjects were divided into two categories depending upon whether or not they mentioned religious activities and/or made positive comments about religious beliefs at any point during the intake session or the first two therapy sessions. As can be seen in the data summarized in Table G-15, an extremely small percentage of those who were religious dropped out before the third therapy session, while a quarter of those not reporting religious thoughts or activities dropped out during that period. Over three-quarters of the religious clients and 54.6% of those

who did not mention religion persisted to the tenth session. More than three-fifths of the religious clients persisted to the twentieth session, while only 45.3% of those reporting no religious activity or beliefs remained in therapy that long. A chi-square test for homogeneity indicated that the difference between the persistence patterns of these two groups was significant, $\chi^2(3, n = 210) = 8.29$, $p < .04$). This evidence did not support Prediction 10e and indicated that religious belief and activity correlated positively with persistence. One interpretation of this finding could be that clients' religious beliefs reinforced their belief or hope that therapy might lead to an improvement in their situation or resolution of their problems.

Relationship to Residence.

Hypothesis 11. The eleventh hypothesis was that community residents and residents of institutions would differ from each other in their persistence in therapy. The prediction was that subjects who resided in communities would have dropped out of therapy more frequently than subjects who resided in institutions.

As can be seen in the data summarized in Table G-15, a majority of the community residents dropped out of therapy before the tenth session, while only two-fifths of the institutionalized clients dropped out before that point. Only a third of the community residents stayed in therapy to the twentieth session, while almost three-quarters of the residents of institutions did. A chi-square test for homogeneity demonstrated that the difference between the persistence patterns of

these two populations was significant, $\chi^2(6, n = 197) = 20.45$, $p < .002$.

A number of reasons could have accounted for this finding. To some extent, institutionalized clients were a captive audience. It was difficult for them to stop treatment when the therapist had the ability to come to their residence. Some institutionalized clients may simply have enjoyed the social interaction and continued it because it was a break from the routine and boredom of the institutional environment. To some degree, the passivity associated with residents of long-term care institutions may have caused them to continue therapy because it was part of the routine and they had learned not to thwart the wishes of the staff who obviously had substantial control over their lives. On the other hand, community residents had greater control over their personal lives and might have felt freer to terminate therapy whenever they desired. For those community residents who saw the therapist at a clinic rather than in their homes, it was easy to not show up for a session or to cancel it with a simple and relatively impersonal telephone call. Finally, community residents had greater access to alternative support systems or stress-reducing activities. An alternative explanation of the pattern may be that the problems of clients residing in institutions may have been more troublesome than those experienced by community residents.

Barriers to Treatment.

Hypothesis 12. The twelvth hypothesis was that the factors identified as barriers to treatment which tend to prevent elderly people

from entering psychological therapy in the first place also would be associated with clients who begin treatment but then drop out. Numerous predictions were based upon this hypothesis.

Level of Education. Prediction 12a was that the subjects' level of formal education would have positively correlated with persistence in therapy. Only the 154 subjects on whom complete education level information was available were included in the testing of this prediction. Two chi-square tests were used. First, the subjects were divided into those who did not graduate from high school and those who did (see Table G-16). A chi-square test for homogeneity indicated no significant difference between the persistence patterns of those two categories, $\chi^2(3, n = 154) = 2.03, p < .567$. Then the subjects were divided into those who did not attend college and those who did (see Table G-16). A chi-square test for homogeneity indicated no significant difference between the persistence patterns of those two categories, $\chi^2(3, n = 154) = .75, p < .86$. Finally, an analysis of variance conducted on the mean level of education of all subjects in each of the four persistence groups indicated that there was no difference between the means, $F(3, 150) = .157, p < .925$. None of these findings supported Prediction 12a. They indicated, instead, that education level was not related to persistence in therapy. Because data about level of education was missing for 29.5% of the subjects, the reliability of these finding is questionable.

The mean education level for the 154 subjects on whom education data were complete was 11.6 years and the median was 12 years. This was

consistent with the the median of 11 years of education for the elderly population of the United States reported by the United States Senate Special Committee on Aging (1984).

Young-old versus old-old. Prediction 12b was that old-old subjects would have dropped out of therapy more frequently than young-old subjects. In order to test the prediction, the subjects were divided into those aged 60 to 74 and those aged 75 and older (see Table G-16). A chi-square test for homogeneity demonstrated that there was no significant difference between the persistence patterns of these two categories, $\chi^2(3, n = 209) = 2.49, p < .477$). The mean ages of the clients in each persistence group were as follows: Group 1, 74.4 years; Group 2, 74.0 years; Group 3, 76.3 years; Group 4, 76.0 years. An analysis of variance on these means indicated that the differences between them were insignificant, $F(3, 205) = .76, 205, p < .518$). The evidence clearly failed to support Prediction 12b. Age was not related to persistence or drop out.

That finding contradicted the previous studies (Baekeland and Lundwall, 1975) which implicated increasing age as a drop-out risk factor. The finding in this study may have been shaped by the special services provided by the Senior Support Team (e.g. special focus on elderly clients, affinity toward the elderly, outreach efforts) which may have encouraged persistence in therapy . Another factor may have been the substantial number of elderly subjects included in this study. Previous studies have included relatively few elderly clients (e.g. $n = 21$ in Raynes and Warren, 1971). Finally, this study differed from the

earlier ones by including a substantial number of subjects who resided in nursing homes and rest homes. Although the mean age of the residents of institutions was higher than that of the community residents, their drop-out rate was lower, as was noted earlier in this paper.

In fact, the evidence gathered in this study called into question the common assumption that increasing age is a barrier to treatment which discourages people from entering therapy in the first place. No empirical evidence has ever been presented to support that contention. In this study the mean age for the subjects was 75.3 and the median age was 74.9. Thus almost equal numbers of people under and over age 75 entered therapy. If the subjects from age 60 to 64 are eliminated from consideration, the young-old (ages 65-74) totaled only 108 and the old-old (age 75 and older) totaled 151. Obviously the old-old did not face substantial barriers which discouraged them from entering therapy from the Senior Support Team.

Crisis. Prediction 12c was that subjects in crisis would have dropped out of therapy less frequently than other subjects. The prediction was tested against information collected about whether or not subjects reported themselves to be in crisis during the intake session and the first ten therapy sessions. As can be seen in the summary in Table G-16, almost equal percentages of clients who never reported themselves to be in crisis and clients who reported themselves to be in crisis at some point during the first ten sessions dropped out of therapy before the tenth therapy session. A chi-square test for homogeneity did not indicate a significant difference between the

persistence patterns of subjects reporting crisis and those not reporting crisis, $\chi^2(3, n = 210) = .461, p < .927$. That result did not support Prediction 12c and indicated that the presence or absence of feelings of crisis are not related to persistence in therapy.

Therapy site. Prediction 12d was that among subjects who resided in communities, those who received therapy in a clinic would have dropped out of therapy more frequently than those who received therapy on an outreach basis in their homes. As can be seen in Table G-16, about two thirds of the community resident clients seen at the center completed fewer than 10 therapy sessions, while less than half of the community residents seen in their homes failed to persist to the tenth session. Less than a quarter of those who went to a clinic continued to at least the twentieth session, while over a third of those receiving treatment in their homes completed at least twenty sessions. A chi-square test for homogeneity indicated, however, that there was no significant difference in the persistence patterns of clients receiving therapy at home and those receiving therapy in the mental health center, $\chi^2(3, n = 127) = 4.66, p < .199$. Prediction 12d was not supported by the data.

The finding that providing mental health services to elderly clients on an outreach basis in their own homes did not increase persistence in therapy is of questionable validity. The clients in the two groups were self-selected because clients had the option of therapy in their home or at the Senior Center. The results may have been influenced by the fact that those who went to the center for treatment probably were physically more able, more mobile and may have had better support systems. The

Senior Center was located in a building separate from the main mental health center. Perhaps the subjects receiving treatment in a therapist's office would have been less persistent if that office had been located with the main mental health center offices.

Gender. Prediction 12e was that male subjects would have dropped out of therapy more frequently than female subjects. As can be seen in Table G-16, somewhat more male subjects than female subjects dropped out before both the tenth session and the twentieth session points. However, a chi-square test for homogeneity did not find a significant difference between the persistence patterns of men and women, $\chi^2(3, n = 210) = 3.51, p < .319$. Prediction 12e was not supported by this data and analysis.

The finding that elderly males and elderly females were almost equally persistent in therapy differed from an observation made by Baekeland and Lundwall (1975). They indicated that among adults in therapy, men were greater drop-out risks than women, although they did not provide a rationale for that conclusion. The finding in this study may have meant that, although there are gender differences in drop-out patterns among the general adult population, there are none among the elderly. Another possibility might be that Baekeland and Lundwall's observation was inaccurate.

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS

This exploratory study was the first attempt to investigate the referral and drop-out patterns of elderly people who received psychotherapy from a community mental health center. Most of the findings (summarized in Table G-17) were preliminary and should serve to direct future research. Because this was a retrospective study, the greatest need is for controlled, experimental research which would produce more reliable and valid results.

Referrals

Sources of Referrals

Most of the clients who resided in the community were referred by in-home service providers, such as home care aides and VNA personnel. Relatively few clients were referred by members of their family or a physician.

The high rate of referral from in-home service providers was probably the result of several factors. To some extent, it was probably the result of the frequency with which these elders interacted with in-home service workers and the infrequency of their interactions with relatives and physicians. To some extent this may have been the result of the in-home service providers' awareness of the community mental health center and its services. It may also have resulted from the

in-home service workers' sensitivity to the problems of the elderly and their inclination to seek professional help to address those problems. It may also be the result of a higher rate of mental disorder or suffering among the people whose physical problems put them in need of in-home services.

The exact reasons for the low rate of referral from relatives and physicians were not addressed in this research and deserve further study. In many cases, relatives and physicians should be able to observe symptoms of mental disorders in elders and it seems likely that they do observe them. They also are the only people who are likely to observe such symptoms in elders who live alone and who are not receiving some type of in-home service. Why they do not make referrals for professional services when appropriate more often can only be hypothesized at this point. The causes may be a lack of information, a fear of upsetting the elder, a belief that the problem is not resolvable, a tendency to solve the problem with medication or some other factor. Certainly research is needed on this question.

In the meantime, community mental health services which offer psychotherapy for elders can proceed in two directions. If they wish to increase the number of referrals with the least amount of effort, they should distribute information about their services to agencies which provide in-home services. A combination of workshops with in-home service personnel and some printed information would probably generate a substantial number of referrals. If they wish to meet the needs of elders who live alone and who do not receive in-home services, they

should make the greater effort to contact physicians and the general public. The former could be contacted via workshops and brochures. Contacting the general public would probably require public service announcements, brochures and workshops in such places as meal sites, churches, elder housing projects and senior centers.

Most clients who lived in long-term care facilities, such as nursing homes and rest homes, were referred by the social workers in those institutions. Very few of the clients who resided in institutions were referred by their relatives or physicians. The reasons for these patterns are probably the same as those previously hypothesized for the referral patterns of community residents.

Since many nursing homes have a small social work staff and some rest homes do not have any social workers at all, some effort should be made to get information about the availability of mental health services to nurses aides and nurses. They should be encouraged to report symptoms of mental disorders to a social worker or the facility director. Additional research is also needed to determine if there are other residents of institutions in need of psychological treatment who are not being referred for services.

Less than a fifth of the clients were self-referred, and most of them were community residents. The reasons for this can only be hypothesized at this point. The causal factors may include negative attitudes toward mental health services, a belief that mental health problems are not resolvable, a failure to recognize the need for professional help and a lack of familiarity with the services available.

More research is needed on this topic.

Unfortunately, there is little that community mental health centers can do to increase self-referrals. Public service announcements, workshops at senior centers and churches, brochures and telephone hot lines are all possibilities, but they are all of questionable efficiency and expensive.

Reasons for Referrals

Nearly half of the clients were referred for emotion-based problems. Depression was the primary reason for the referral of community residents and the second most common reason for the referral of residents of institutions. It is doubtful that all of the people referred for that reason were actually suffering from clinical depression, since a third of the people referred for depression were ultimately diagnosed by their therapists as having some other problem. Nevertheless, depression-like symptoms frequently induced people to refer elders for mental health services and it actually was clinically diagnosed in two thirds of those cases. Adjustment problems, the most common diagnosis, were the reasons for a much smaller number of referrals.

Management problems were the second most frequent reason for referral. Although residents of institutions were more often referred for this reason than community residents, management problems were the reason given in less than half of referrals for even the institution-residing population. Referrals for emotional problems and family conflict together outnumbered those for management problems

regardless of whether clients resided in the community or in long-term care facilities.

That finding implies that community mental health centers should direct more of their efforts toward residents of institutions. Such people do suffer from emotional disorders and they are referred for them when the availability of service is made known. The usual current practice of limiting mental health services to the residents of communities or limiting services for residents of institutions to case consultation is not sufficient. Serving that population will necessitate outreach work in the institutions, but having a therapist visit a few rest homes and nursing homes would involve less expense than visiting community residents in their more widely scattered homes.

Family conflict was the reason for about a third of all referrals. It was more common among community residents than residents of institutions and it was the most frequent reason why clients referred themselves. More research is needed on the factors which contribute to the conflict and the therapeutic approaches which are effective in helping elderly people to cope with their family related problems. The frequency of the problem indicates that community mental health centers should consider providing family therapy as a regular service to the elderly.

Crisis seems to have played a major role in bringing clients into therapy. A quarter of the clients were in crisis at intake and almost a half were reported to be in crisis at some point during the first ten therapy sessions. This high frequency of crisis highlights the

seriousness of the mental health problems of the elderly and their need for community mental health services.

Diagnoses

Although clients were classified into a wide variety of DSM III diagnostic categories, the majority of clients were found to have adjustment disorders, organic brain disorders, affective disorders or conditions not attributable to a mental disorder.

As expected, residents of institutions were diagnosed more often than community residents as having organic brain disorders, schizophrenia, paranoid disorders and psychotic disorders. This may have been caused by a high rate of referral of residents of institutions when these disorders resulted in disruptive behaviors. It may also have reflected a somewhat higher than normal frequency of serious mental disorders among the residents of nursing homes which received some of the former patients deinstitutionalized from a state mental hospital.

Almost equal percentages of community residents and residents of institutions were diagnosed with emotion-based problems.

These findings indicate that community mental health centers need to employ therapists who are able to deal with a wide variety of psychological problems and who are knowledgeable about the special problems often associated with the elderly, particularly organic brain disorders and strategies to reduce disruptive behavior.

Complaints

The most common complaint made by clients during therapy was of difficulties with their spouse and/or children. About half the community residents and a quarter of the residents of institutions made such complaints. This finding and the high rate of referral for family conflict highlight the close association between mental illness in the elderly and family problems. Further research is needed to determine the causal relationship between family problems and mental illness. The finding certainly reinforces the recommendation that community mental health centers should provide family therapy and that they should employ therapists qualified to provide that service.

Three of the six most common complaints concerned physical health problems (poor health, physical limitations, aches and pains). This evidence supported the well-documented relationship between physical and mental health. It also implies that community mental health centers should offer therapeutic approaches designed to help clients deal with chronic pain and to help them cognitively restructure their perception of their health.

Relatively few differences were found between the type of complaints made by people in different residential situations. There was also little difference between the complaints made by men and women. These findings indicated that, for the most part, clients experienced stressful events and problems more or less equally regardless of where they lived or their gender. The one notable exception was that women

complained significantly more often than men about a lack of social involvement. Research is needed on the effect an increase in social activity would have on the mental health of elderly women who complain in therapy about their social isolation.

Termination of Therapy

The vast majority of clients terminated their own therapy. Only a small percentage of the clients had their therapy terminated at the suggestion of, or with the mutual agreement of, their therapist. More research is needed to determine if this is indeed the normal pattern for elders receiving mental health services and if it is, why it is. In the mean time, therapists should work toward involving elderly clients in the determination of what therapy needs to be done and when therapy should conclude.

Clients with organic brain disorders and psychotic disorders were less likely than other clients to terminate their own therapy. In a majority of these cases the therapist terminated treatment, with or without the agreement of the client. More research is needed on whether and to what degree such clients are capable of participating in and benefiting from the therapeutic process.

Clients who resided in institutions or who moved into nursing homes during the course of their therapy did not terminate their own treatment as frequently as those who resided in communities. This raises an ethical question about whether residents of institutions felt able to

terminate therapy when they wished to do so. It is possible that people who had adopted the passive role of patient under the supervision of a professional staff may have felt unable to refuse treatment recommended by that staff. It is notable that residents of institutions who did terminate their own therapy frequently mentioned that the process was painful for them (e.g. brought back unpleasant memories). Because they are dealing with what is essentially a captive audience, therapists should be cautious in the manner in which they raise and deal with issues during therapy with residents of institutions. They should be particularly sensitive to signs that residents of institutions are reluctant to continue treatment.

Persistence in Treatment

Significant relationships were discovered between patterns of persistence in therapy and various client characteristics, such as diagnosis, availability of social support, and religion. In all cases these findings were somewhat preliminary and tentative and serve mostly to direct further research. On the other hand, they have very practical implications for clinical practice and for community mental health center policy. If clients who are at great risk of dropping out could be identified on the basis of information collected about them at intake sessions, therapists could take appropriate action. In some cases this might mean using brief therapy to accomplish the greatest amount of treatment before the clients drop out. In other cases, particularly

when the clients' problems are severe, it might mean adopting strategies designed to increase the probability of persistence.

Relationship to Self-Referral

No significant differences were discovered between the persistence patterns of clients who referred themselves into therapy and those who were referred by someone else. This finding provides support to those community mental health center therapists and administrators who favor a policy of actively encouraging self-referrals by elders who need mental health services, usually by means of public service announcements, outreach services and the distribution of literature. The finding somewhat undermines the position of other community mental health center therapists and administrators who argue 1) that the lack of self-referrals indicates a lack of interest by elders in therapy and 2) that if people who are not interested are recruited into therapy, they are likely to drop out before any meaningful treatment is accomplished, wasting the time of both the therapists and those who did the recruiting.

Relationship to Diagnoses and Psychiatric Symptoms

The study discovered evidence that there is a relationship between diagnoses and psychiatric symptoms and persistence patterns. Clients in two categories were significantly more persistent in therapy than others: clients with paranoid ideation and clients with conditions which caused intense discomfort (e.g. organic brain, anxiety, somatoform and affective disorders). The finding concerning paranoid clients ran counter to the findings of earlier research concerning persistence

patterns among adults in general which were interpreted as meaning that paranoid people dropped out of therapy because they tended to distrust their therapists (Baeleland and Lundwall, 1975). It may indicate that elders with paranoid ideation are more capable than the general adult population of sorting through their fears, realizing that they need professional help and continuing treatment in the hope of resolving their problems. Clients in the second group may have been more persistent because they were desperate for relief from their painful symptoms.

Relationship to Support from Family, Friends and Religion

Access to support from relatives was not found to be related to persistence in treatment. This implied that relatives were not able to reduce the clients' needs for professional help and it may even have indicated that, in some cases, members of the clients' families were involved in their problems.

Clients who complained about a poor social life and loneliness were significantly more persistent in therapy than other clients. Additional research is needed to assess the validity of this finding and to determine what means might be used to effectively increase the social interaction of clients who feel socially isolated.

Clients who reported a positive religious belief or religious activity were significantly more persistent in therapy than other clients.

Relationship to Residence

Clients residing in institutions, such as nursing homes, were more

persistent than clients residing in communities. This pattern was probably related to the previously mentioned finding that residents of institutions terminated their own therapy much less often than community residents. It is also probable that both of these patterns were related to the passive patient role often adopted by residents of institutions. It is possible that some residents of institutions wanted to terminate their treatment, but felt unable to do so. Another possibility is that some residents of institutions found the visits by therapists to be a pleasant break from the routine of the institution.

Relationship to Barriers to Treatment

None of the factors which have been identified as barriers to treatment which discourage elderly people from entering psychotherapy in the first place (Gaitz, 1974; Knight, 1978-79) were found to be related to patterns of persistence in therapy.

There was no significant relationship between level of education and persistence in therapy, although this finding is particularly unreliable because complete information was available about the education of only three-quarters of the subjects on whom persistence analyses were conducted.

There was no significant relationship between the client's ages and their persistence. In fact, the rather large percentage of clients over the age of 75 called into question whether or not increasing age actually is a barrier to treatment.

Although crisis did appear to be a factor which encouraged some clients to enter therapy, it did not appear to be related to whether or

not they persisted in therapy. A substantial number of clients dropped out of treatment while they were still reporting that they were in crisis. This certainly deserves further research because it implies that services are not being provided people who are in great need of them.

There was no significant difference between the persistence patterns of elderly men and elderly women, a discovery which contradicted a previous finding (Baekeland and Lundwall, 1975) that among the general adult population, men were greater drop-out risks than women.

No significant relationship was discovered between the persistence patterns of community residents who were treated in the therapist's office and community residents who were treated in their own homes on an outreach basis. The reliability of this finding is somewhat suspect because the clients in these two groups were self-selected and because those traveling from their homes to the therapists office were probably in better physical condition. This certainly deserves more research because outreach services are expensive and any information which results in more efficient use of them would have immediate application for clinical practice and community mental health center policies.

Conclusion

Several preliminary findings concerning mental health services for the elderly can be drawn from this study. Elders are most frequently referred for mental health services by social service personnel and the

most frequent reasons for referral are emotional problems. Persistence in treatment appears to be more closely related to diagnosis, psychiatric symptoms, religious belief and complaints of loneliness and/or poor social life than it is to whether or not the client is in a crisis state. Because of the retrospective nature of this study, it was not possible to manipulate variables and control for differences in the quality of the psychotherapy. Despite that limitation, the findings clearly indicated a need for a full range of psychological services for elders, including both those residing in communities and those in nursing homes. This indicates a need for more therapists who are familiar with the special problems of the elderly, particularly age-related dementia.

APPENDIX A: Senior Support Team Intake Form

FRANKLIN COUNTY
MENTAL HEALTH CENTER
DEPARTMENT OF MENTAL HEALTH

[illegible]

APPENDIX B: Senior Support Team Intake Interview Guidelines

GUIDELINES FOR INTAKE INTERVIEW SENIOR SUPPORT TEAM

- (1) Date(s) of interview(s) - Type - (Family, individual)
- (2) Identifying Information
 - Include: a) referral source
 - b) physical condition
 - c) medical problems
 - d) family constellation
 - e) living conditions
 - f) economic status
- (3) Presenting Problem(s)
 - Include: a) why referred
 - b) what does client say
 - c) what do others say
- (4) History - document sources
- (5) Current situation
- (6) Impressions/Assessment
 - Include: a) strengths/weaknesses
 - 1) intrapsychic
 - 2) interpersonal
 - 3) environmental
 - b) attitude/readiness for treatment
 - Include: 1) availability for treatment
 - 2) resistance issues
- (7) Treatment Plan
 - Include: a) structure
 - 1) individual, family, group
 - 2) long-term, short-term
 - b) individual's treatment goals

APPENDIX C: Senior Support Team Progress Notes Form

PROGRESS NOTES

Client: _____

Client Case # _____

Date of Contact: _____

Therapist Name: _____

Type of Session: _____

Duration of Session: _____

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

APPENDIX D: Senior Support Team Closing Summary Form

Case Transfer/Closing Summary

Client _____

Case Number _____

Case Transfer/Clinical Summary: Date _____

Primary Therapist _____

Case Summary: Date _____

Primary Therapist _____

Condition: _____

APA Diagnosis _____

Final Disposition _____

APPENDIX E: Data Collection Form 1

Client Case # _____ # of Sessions _____ Community Resident _____ N.H. _____

Date Entered Therapy _____ Date Ended Therapy _____ Therapist's Initials _____

Client Factors:

Male _____ Female _____ Age at time of Intake _____ Is client on Medicaid? _____

<u>Marital Status</u>	<u>Living Arrangements</u>	<u>Educational Level</u> <u>Grade Completed (Circle)</u>
Married _____	Alone _____	6 _____ 12 _____
Widowed _____	With Spouse _____	7 _____ 1 yr college _____
Seperated _____	With child _____	8 _____ 2 _____
Divorced _____	Congregate _____	9 _____ 3 _____
Never Married _____	Housing _____	10 _____ 4 _____
	With a Friend _____	11 _____ Graduate school _____
	N.H. _____	

Family (Living) Constellation:

Spouse _____
 Child _____ # _____ within 20 miles
 Sibling _____ # _____ within 20 miles
 Other _____

Condition of Spouse:

Mentally confused _____
 Physically impaired _____
 Emotionally impaired _____
 Relatively healthy _____
 Other (specify) _____

Who referred the client:

Self _____ Social Worker _____
 Family _____ at N.H. _____
 Social worker _____
 at Hospital _____
 Home Care _____
 Senior Service _____
 Agency _____
 Physician _____
 VNA _____
 Clergyman _____
 Other (Specify) _____

Reason for Referral:

Mental Confusion _____
 Concern over ability to live independently _____
 Concern over depression _____
 Management Difficulties:
 a) Self Care _____
 b) disruptive behavior _____
 Family Conflict _____
 Which member _____
 Other (specify) _____

Did client report being in a crisis situation at any point during the first ten episodes? Yes _____ No _____ Which session(s) _____

Diagnosis (taken from closing statement): Axis I DSM # _____

Deferred _____	OBS _____
Unipolar Depression _____	Schizophrenia _____
Adjustment Disorder _____	Bipolar Disorder _____
Other (specify) _____	

Was paranoid ideation present? YES _____ NO _____

APPENDIX F: Data Collection Form 2

Complaints made during therapy: (frequency count)

Poor health _____	Stress from loss of spouse _____
Physical limitations _____	Inadequate social resources or social Interaction _____
Transportation problems _____	Lack of someone to talk to _____
Lack of sleep _____	Abandoned by family _____
Various aches & pains _____	Loss of work role _____
Feelings of sadness _____	Lack of someone to rely on _____
Loneliness _____	Difficulties with spouse _____
Financial problems _____	Difficulties with children _____
Loss of control _____	Negative perception of current residence _____
Other (specify) _____	
Lack of continuing ties with people in general _____	
Lack of social contact with a preferred person _____	

Comment must
be made
during intake
and/or first
two therapy
sessions

Expression of religion: devout _____
casual comment indicating belief _____
no comment concerning belief _____

Social contacts with Age peers: Reports frequent contact _____
Reports occasional contact _____
Reports very little contact _____
No comment on socialization _____

Confidante: comment indicating having someone to tell problems
to _____
comment indicating not having someone to tell problems
to _____
made no comment concerning whom client confides problems
to _____

Reason for terminating therapy:

Death of client _____
Reports he/she can cope on his/her own _____
Reports he/she does not need therapy _____
Reports not wishing to see the therapist _____
Reports inability to afford therapy _____
Client fails to return (no further contact) _____
Mutually agreed upon by therapist & client _____
Therapist terminated therapy _____ Why? _____

Who terminated therapy:

Client _____
Therapist _____
Other (specify) _____

Psychological condition at time of termination:

Improved _____
Unchanged _____
Condition worse _____

Did client pay for services:
Yes _____ No _____ Don't know _____

Sessions took place:

Client's home _____ The center _____ Outreach office _____
Other (specify) _____

Type of psychotherapy provided:

Individual _____
Couple's _____
Case consultation _____

Family _____ Medication _____
Group _____
Other (specify) _____

APPENDIX G: Tables

Table G-1

Sources of referrals (given in percentages)

Source of Referral	Total Subject Population (N = 298)	Community Residents (n = 182)	Institutionalized Clients (n = 100)	Transfer Clients* (n = 16)
Social service workers	62.4	56.6	69.0	75.2
At nursing homes	22.4	2.2	62.0	0
At acute care hospitals	8.4	9.9	4.0	18.8
In-home service workers	17.8	28.0	0	12.6
Senior service agency	6.4	8.8	1.0	12.5
Protective services	1.0	1.6	0	0
Elder day program	5.4	6.6	0	25.0
Rest home director	0.7	0	2.0	0
Foster care program	0.3	0.5	0	0
Self	11.4	17.0	2.0	6.3
Medical professionals	14.4	9.3	24.0	12.6
Physician	7.7	8.8	6.0	6.3
Nurse	6.4	0	18.0	6.3
X-ray technician	0.3	0.5	0	0
Family	5.7	8.8	0	6.3
Mental health services	4.7	4.1	5.0	6.3
Lawyer	1.0	1.6	0	0
Friend	0.3	0.5	0	0
College counselor	0.3	0.5	0	0

* Includes 15 clients who moved into nursing homes and one client who moved out of a nursing home during the course of therapy.

Table G-2

Primary reasons for referrals
(given in percentages)

Reason for Referral	Total Subject Population (N = 298)	Community Residents (n = 182)	Institu- tionalized Clients (n = 100)	Transfer Clients* (n = 16)
Depression	32.2	34.6	27.0	37.5
Management problems	21.1	8.8	45.0	12.5
Family conflict	19.5	27.5	8.0	0
Concern about ability to live independently	8.1	10.4	1.0	25.0
Adjustment problem	4.7	3.3	8.0	0
Anxiety	4.0	4.9	3.0	0
Unusual behavior	3.0	2.7	2.0	12.5
Mental confusion	2.0	1.1	2.0	12.5
Concern about spouse	1.7	2.2	1.0	0
Support	1.0	1.1	1.0	0
Terminal illness	0.7	0.5	1.0	0
Medical problem	0.7	1.1	0	0
Lonelines/isolation	0.7	0.5	1.0	0
Alcoholism	0.3	0.5	0	0
Court order	0.3	0.5	0	0

* Includes 15 clients who moved into nursing homes and one client who moved out of a nursing home during the course of therapy.

Table G-3

Secondary reasons for referrals
(given in percentages)

Reason for Referral	Total Subject Population (N = 298)	Community Residents (n = 182)	Institu- tionalized Clients (n = 100)	Transfer Clients* (n = 16)
Depression	30.8	11.5	10.0	12.5
Management problems	6.5	2.7	1.0	6.3
Family conflict	19.6	7.7	5.0	12.5
Concern about ability to live independently	3.7	1.1	2.0	0
Adjustment problem	5.6	0.5	5.0	0
Anxiety	4.6	2.7	0	0
Unusual behavior	8.4	1.6	3.0	0
Mental confusion	22.4	5.5	13.0	6.3
Lonelines/isolation	1.0	0.5	0	0

* Includes 15 clients who moved into nursing homes and one client who moved out of a nursing home during the course of therapy.

Table G-4

Percentage of clients in crisis
during intake session and first ten therapy sessions

	Total Subject Population (N = 298)	Community Residents (n = 182)	Institu- tionalized Clients (n = 100)	Transfer Clients* (n = 16)
Subjects who reported being in crisis	51.7	52.7	45.0	81.3
Intake session	26.6	32.0	20.0	7.7
Session 1	10.4	12.4	8.9	0
Session 2	15.6	17.5	13.3	7.7
Session 3	9.7	10.3	8.9	7.7
Session 4	7.8	5.2	11.1	15.4
Session 5	9.0	8.2	8.9	15.4
Session 6	4.5	3.0	6.7	7.7
Session 7	3.9	3.0	6.7	0
Session 8	1.9	0	2.2	15.4
Session 9	1.3	2.0	0	0
Session 10	9.7	6.2	13.3	23.0
Subjects who did not report being in crisis	48.3	47.3	55.0	18.8

* Includes 15 clients who moved into nursing homes and one client who moved out of a nursing home during the course of therapy.

Table G-5

Cross-tabulation of sources of referrals with reasons for referrals
(given in percentages)

Reason for referral	Social worker at nursing home n = 66	In- home service n = 53	Self n = 34	Social worker at hospital n = 25	Physician n = 23
Depression	26.5	41.5	26.5	40.0	60.6
Management problem	0	7.5	0	4.0	8.7
Family conflict	44.1	18.9	25.9	16.0	8.7
Concern about ability to live independently	8.8	15.0	8.8	8.0	4.3
Adjustment problem	0	5.7	0	12.0	4.3
Anxiety	5.7	3.8	5.9	12.0	4.3
Unusual behavior	0	5.7	0	0	0
Mental confusion	0	1.8	0	8.7	8.7
Concern about spouse	5.9	0	5.9	0	0
Support	0	0	0	0	0
Terminal illness	0	0	0	4.0	0
Medical problem	5.9	0	5.9	0	0

Note: Table includes only sources which referred four or more clients
and reasons which were given for two or more referrals.

(continued on next page)

Table G-5 (continued)

Cross-tabulation of sources of referrals with reasons for referrals
(given in percentages)

Reason for referral	Senior service agency n = 66	Nursing home nurse n = 53	Family n = 34	Elder day center n = 25	Mental health services n = 23
Depression	15.8	21.1	41.2	12.5	28.6
Management problem	15.8	31.6	35.3	18.8	28.5
Family conflict	26.3	10.5	17.6	43.8	7.1
Concern about ability to live independently	15.8	5.3	5.9	0	21.4
Adjustment problem	0	15.8	0	0	7.1
Anxiety	5.3	5.3	0	0	0
Unusual behavior	10.5	5.3	0	6.3	0
Mental confusion	0	0	0	12.5	0
Concern about spouse	0	0	0	0	7.1
Support	5.3	5.3	0	6.3	0
Terminal illness	0	0	0	4.0	0
Medical problem	0	0	0	0	0

Note: Table includes only sources which referred four or more clients
and reasons which were given for two or more referrals.

Table G-6

Principal diagnoses
(given in percentages)

Diagnoses	Total Subject Population (N = 298)	Community Residents (n = 182)	Institu- tionalized Clients (n = 100)	Transfer Clients* (n = 16)
Adjustment disorder	39.6	42.3	36.0	31.3
Affective disorder	12.8	11.0	15.0	18.8
Organic brain disorder	11.1	5.5	20.0	18.8
Conditions not attributable to a mental disorder	8.8	9.3	5.0	12.5
Schizophrenia	4.7	3.3	8.0	0
Personality disorder	4.4	4.4	5.0	0
Anxiety disorder	4.0	6.0	1.0	0
Paranoid disorder	1.3	2.2	0	0
Psychotic disorder	1.3	0.5	3.0	0
Substance use disorder	1.3	2.2	0	0
Somatoform disorder	1.3	2.2	0	0
Paraphilias	1.0	1.6	0	0
Psychological factors af- fecting physical condition	0.7	0.5	0	6.3
Deferred diagnosis	8.4	8.8	7.0	12.5

* Includes 15 clients who moved into nursing homes and one client who moved out of a nursing home during the course of therapy.

Table G-7

Complaints made during therapy
(given in percentages)

Complaint	All Subjects Analyzed (n = 280)	Community Residents (n = 181)	Institu- tionalized Clients (n = 83)	Transfer Clients* (n = 16)
Difficulty with spouse and/or children	47.5	57.5	26.5	43.7
Poor health	41.8	45.8	31.3	50.0
Lack of personal control over environment	41.4	37.6	48.2	50.0
Physical limitations	33.6	29.8	41.0	37.5
Loneliness	33.6	35.4	26.5	50.0
Aches and pains	30.4	28.2	34.9	31.3
Sadness	27.9	26.0	30.1	31.3
Loss of spouse	23.9	26.0	18.1	31.3
Abandoned by family	21.8	16.0	26.5	63.0
No one to rely upon	20.7	21.0	16.9	37.5
Negative perception of current residence	20.4	11.6	36.1	37.5
Poor social life	16.0	17.7	14.5	6.3
Loss of work role	13.6	12.2	14.5	25.0
Financial problems	12.5	12.2	12.0	18.8
Anger	11.8	8.3	16.9	25.0
Lack of someone to talk to	11.0	10.5	13.3	6.3
Lack of sleep	9.3	13.8	14.5	43.7
Lack of independence	7.9	6.0	12.0	6.3
Lack of continuing ties	7.8	8.3	7.2	6.3
Lack of contact with a preferred person	6.0	5.0	9.6	0
Cognitive losses	6.0	0.6	20.5	0
Fear of death	5.7	5.5	7.2	0
Transportation problems	3.6	5.0	0	6.3
Loss of a child or parent	4.2	4.4	3.6	6.3
Difficulty with roommate	0.7	0	2.4	0

* Includes 15 clients who moved into nursing homes and one client who moved out of a nursing home during the course of therapy.

Table G-8

Complaints tabulated by gender
(given in percentages)

Complaint	Males (n = 63)	Females (n = 185)	χ^2 (1, n=248)	p <
Difficulty with spouse and/or children	41.3	50.8	1.352	.245
Poor health	38.1	40.0	.014	.906
Lack of personal control over environment	44.4	40.0	.222	.638
Physical limitations	38.1	31.9	.557	.455
Loneliness	31.7	35.7	.170	.680
Aches and pains	17.5	33.5	5.084	.024
Sadness	30.2	27.6	.054	.816
Loss of spouse	23.8	24.9	0	1.000
Abandoned by family	11.1	23.2	3.577	.059
No one to rely upon	14.3	22.7	1.555	.212
Negative perception of current residence	17.5	19.5	.027	.870
Poor social life	15.9	18.4	.067	.796
Loss of work role	22.2	10.8	4.253	.039
Financial problems	12.5	12.4	0	1.000
Lack of someone to talk to	14.3	10.8	.265	.607
Lack of sleep	7.9	16.2	2.019	.156
Lack of independence	14.3	5.9	3.356	.067
Lack of continuing ties	6.3	9.2	.191	.662
Lack of contact with a preferred person	3.2	5.9	.276	.600
Cognitive losses	7.9	6.5	.011	.917
Fear of death	7.9	4.9	.356	.551
Transportation problems	0	4.3	1.600	.206
Difficulty with roommate	0	0.5	0	1.000

Table G-9

Complaints tabulated by gender and residence
(given in percentages)

Complaint	Community Residents		Residents of Institutions	
	Male (n = 42)	Female (n = 125)	Male (n = 20)	Female (n = 48)
Difficulty with spouse and/or children	50.0	60.0	25.0	25.0
Poor health	47.6	49.4	20.0	33.3
Lack of personal control over environment	38.1	36.8	60.0	43.8
Physical limitations	33.3	28.0	45.0	41.7
Loneliness	31.0	38.4	35.0	25.0
Aches and pains	9.5	33.6	35.0	35.4
Sadness	33.3	24.8	25.0	33.3
Loss of spouse	26.2	27.2	20.0	16.7
Abandoned by family	4.8	19.2	20.0	22.9
No one to rely upon	19.0	22.4	0	20.8
Negative perception of current residence	4.8	12.8	40.0	33.3
Poor social life	14.3	20.0	20.0	16.7
Loss of work role	19.0	9.6	30.0	10.4
Financial problems	9.5	13.6	15.0	10.4
Lack of someone to talk to	11.9	10.4	20.0	14.6
Lack of sleep	3.4	16.8	15.0	9.3
Lack of continuing ties	4.8	10.4	10.0	6.3
Lack of contact with a preferred person	2.4	4.0	5.0	12.5
Cognitive losses	2.4	3.2	20.0	14.6
Fear of death	7.1	4.8	10.0	6.3
Transportation problems	0	5.6	0	0
Difficulty with roommate	0	0	2.1	0

Table G-10

Reasons therapy terminated
(given in percentages)

Reason for Terminating Therapy	Total Subject Population (N = 298)	Community Residents (n = 182)	Institu- tionalized Clients (n = 100)	Transfer Clients (n = 16)
Client initiated	47.7	62.8	24.0	31.1
Said can cope by self	18.0	27.0	4.0	12.5
Refused to see therapist without explanation	6.0	5.5	5.0	12.5
Said therapy is too painful	5.0	3.0	10.0	0
Failed to return or can- celed remaining sessions	5.0	8.8	0	0
Said therapy will not help	4.0	4.4	1.0	6.3
Relocated to institution	3.0	2.1	2.0	0
Moved out of service area	3.0	4.9	1.0	0
Difficulty transitioning to new therapist	2.0	2.7	0	0
Denied problem	1.0	1.8	0	0
Cannot afford therapy	1.0	1.1	0	0
Sought therapy elsewhere	0.3	0.5	0	0
Refused to talk	0.3	0	1.0	0
Refused to attend without a family member	0.3	0.5	0	0
Therapist initiated	29.9	17.5	50.0	50.0
Problem resolved or improved	9.0	4.4	15.0	25.0
Therapist left agency	6.0	3.3	10.0	12.5
Client had limited capa- city for therapy	5.0	3.8	8.0	0
Mental confusion	4.0	1.1	8.0	6.3
Client not motivated	4.0	4.4	3.0	6.3
Physical deterioration of client	1.0	0	3.0	0
Request by another professional	1.0	0.5	2.0	0
Problem with institution	0	0	1.0	0
Mutually decided upon by client and therapist	9.7	11.5	7.0	0
Client too ill to continue	0	0.5	0	0
Client died	12.0	8.2	19.0	18.9

Table G-11

Cross-tabulation of diagnoses with who terminated therapy
(given in percentages)

Diagnosis	Person who initiated termination of therapy			
	Client	Therapist	Mutual Agreement	Other Professional
Deferred diagnosis (<u>n</u> = 25)	68.0	24.0	8.0	0
Affective disorder (<u>n</u> = 38)	60.5	34.2	5.3	0
Adjustment disorder (<u>n</u> = 118)	62.7	27.1	10.2	0
Organic brain disorder (<u>n</u> = 33)	30.3	60.6	6.1	3.0
Schizophrenia (<u>n</u> = 14)	57.1	35.7	7.1	0
Paranoid Disorder (<u>n</u> = 4)	75.0	25.0	0	0
Anxiety disorder (<u>n</u> = 12)	58.3	25.0	16.7	0
Substance use disorder (<u>n</u> = 4)	50.0	25.0	25.0	0
V-codes (<u>n</u> = 23)	65.2	13.0	21.7	0
Personality disorder (<u>n</u> = 13)	84.6	7.7	7.7	0
Psychotic disorder (<u>n</u> = 4)	25.0	25.0	25.0	25.0
Paraphilias (<u>n</u> = 3)	100.0	0	0	0
Somatoform disorder (<u>n</u> = 4)	75.0	25.0	0	0
Conditions not attribut- able to a mental disorder (<u>n</u> = 1)	0	100.0	0	0
Psychological factors affecting physical condition (<u>n</u> = 2)	100.0	0	0	0

Table G-12

Persistence in therapy

	Number of Therapy Sessions Attended			
	Group 1 No more than 2	Group 2 3 - 9	Group 3 10 - 19	Group 4 20 or more
All Subjects analyzed concerning persistence and drop-out (<u>n</u> = 210)	21.0	20.5	10.5	48.1
Sources of Referrals				
Self (<u>n</u> = 26)	34.6	19.2	11.5	34.6
Others (<u>n</u> = 184)	19.2	20.7	10.3	50.0
Paranoid Symptoms				
Paranoid ideation (<u>n</u> = 51)	9.8	23.5	5.9	60.8
No paranoid ideation (<u>n</u> = 157)	24.8	18.5	12.1	44.6
Diagnosis of Depression				
Diagnosed with depression (<u>n</u> = 117)	18.8	20.5	11.1	49.5
Not diagnosed with depression (<u>n</u> = 93)	23.7	20.4	9.7	46.2

Note: Groups 1, 2 and 3 include only subjects who terminated their own therapy. Group 4 includes all subjects who attended at least 20 therapy sessions

Table G-13

Persistence in therapy cross-tabulated with diagnosis

	Number of Therapy Sessions Attended			
	Group 1 No more than 2	Group 2 3 - 9	Group 3 10 - 19	Group 4 20 or more
Diagnosis				
Affective disorder (<u>n</u> = 27)	14.8	14.8	3.7	66.7
Adjustment disorder (<u>n</u> = 90)	20.2	22.2	13.3	44.4
V-codes (<u>n</u> = 16)	37.5	18.8	18.8	25.0
Personality disorder (<u>n</u> = 12)	8.3	50.0	16.7	25.0
Somatoform disorder (<u>n</u> = 4)	0	25.0	0	75.0
Anxiety disorder (<u>n</u> = 7)	14.3	0	14.3	71.4
Organic brain disorder (<u>n</u> = 15)	6.7	6.7	6.7	80.0
Substance use disorder (<u>n</u> = 2)	50.0	0	50.0	0
Schizophrenia (<u>n</u> = 9)	11.1	33.3	11.1	44.4
Deferred diagnosis (<u>n</u> = 18)	44.4	16.7	0	38.9
Paranoid disorder (<u>n</u> = 4)	50.0	0	0	50.0
Psychotic disorder (<u>n</u> = 2)	0	50.0	0	50.0
Paraphilias (<u>n</u> = 2)	0	100.0	0	0
Psychological factors affecting physical condition (<u>n</u> = 2)	50.0	0	0	50.0

Note: Groups 1, 2 and 3 include only subjects who terminated their own therapy. Group 4 includes all subjects who attended at least 20 therapy sessions.

Table G-14

Persistence in therapy cross-tabulated with family relationships
(given in percentages)

	Number of Therapy Sessions Attended			
	Group 1 No more than 2	Group 2 3 - 9	Group 3 10 - 19	Group 4 20 or more
Married (<u>n</u> = 59)	30.5	20.3	11.9	37.3
Widowed (<u>n</u> = 104)	16.7	20.7	10.0	52.7
Married community residents (<u>n</u> = 48)	37.5	25.0	12.5	25.0
Widowed community residents (<u>n</u> = 67)	25.4	25.4	14.9	34.3
Widowed with living child(ren) (<u>n</u> = 82)	20.7	18.3	14.6	46.3
Widowed without living child(ren) (<u>n</u> = 22)	21.1	21.9	7.8	49.2
Widowed community residents with living child(ren) (<u>n</u> = 54)	25.9	18.5	18.5	37.0
Widowed community residents without living child(ren) (<u>n</u> = 12)	25.0	50.0	0	25.0
Widowed community residents with child(ren) living within 20 miles (<u>n</u> = 48)	22.9	18.8	18.8	39.6
Widowed community residents with no child(ren) living within 20 miles (<u>n</u> = 18)	33.3	38.9	5.6	22.2
Client reported difficulty with spouse and/or child(ren) (<u>n</u> = 97)	23.7	20.6	13.4	42.3
Client reported no difficulty with spouse and/or child(ren) (<u>n</u> = 61)	19.7	18.0	11.5	50.8

Note: Groups 1, 2 and 3 include only subjects who terminated their own therapy. Group 4 includes all subjects who attended at least 20 therapy sessions.

Table G-15

Persistence in therapy cross-tabulated with social relationships, religion and residence (given in percentages)

	Number of Therapy Sessions Attended			
	Group 1 No more than 2	Group 2 3 - 9	Group 3 10 - 19	Group 4 20 or more
Social relationships				
Client reported adequate social activity or made no complaint about social activity (<u>n</u> = 108)	20.9	20.9	16.3	41.7
Client complained about inadequate social life (<u>n</u> = 102)	18.6	25.6	7.0	48.8
Religion				
Client made positive comments about religion (<u>n</u> = 38)	5.7	18.4	15.8	60.5
Client made no comments about religion (<u>n</u> = 172)	24.4	20.9	9.3	45.3
Residence				
Community (<u>n</u> = 135)	28.1	25.9	12.6	33.3
Institution (<u>n</u> = 62)	9.7	11.3	6.5	72.6
Transfer (<u>n</u> = 13)	0	7.7	7.7	84.6

Note: Groups 1, 2 and 3 include only subjects who terminated their own therapy. Group 4 includes all subjects who attended at least 20 therapy sessions.

Table G-16

Persistence in therapy cross-tabulated with education, age, crisis, therapy site and gender
(given in percentages)

	Number of Therapy Sessions Attended			
	Group 1 No more than 2	Group 2 3 - 9	Group 3 10 - 19	Group 4 20 or more
Education level				
Did not graduate from high school (<u>n</u> = 62)	17.7	22.6	14.5	45.2
Graduated from high school (<u>n</u> = 92)	15.2	16.3	11.9	56.5
Did not attend college (<u>n</u> = 133)	15.8	18.0	13.5	52.6
Attended college (<u>n</u> = 21)	19.0	23.8	9.5	47.6
Age				
60-74 years (<u>n</u> = 101)	22.8	22.8	9.9	44.6
75 years or older (<u>n</u> = 108)	19.4	17.6	11.1	51.9
Crisis				
In crisis (<u>n</u> = 104)	20.8	19.2	9.6	50.0
Not in crisis (<u>n</u> = 106)	20.8	21.7	11.3	46.2
Therapy site of community residents				
In clinic (<u>n</u> = 34)	41.2	26.5	8.8	23.5
In home (<u>n</u> = 93)	24.7	22.6	15.0	37.6
Gender				
Males (<u>n</u> = 51)	23.5	27.5	5.9	43.1
Females (<u>n</u> = 159)	20.1	18.2	11.9	49.7

Note: Groups 1, 2 and 3 include only subjects who terminated their own therapy. Group 4 includes all subjects who attended at least 20 therapy sessions.

Table G-17

Summary of significant findings

Topic	Finding	Significance Level
Referral	Clients were referred more often by social service agencies than by relatives.	$p > .001$
Referral	Clients were referred more often by social service agencies than by physicians.	$p > .001$
Referral	Community residents were more often referred for emotional problems than for management difficulties or concern about capacity for independent living.	$p > .001$
Referral	Clients in institutions were referred more often than community residents for management problems.	$p > .001$
Diagnosis	Clients in institutions had a higher frequency of organic brain disorder, schizophrenia, paranoid disorders and psychotic disorders than did community residents.	$p > .001$
Complaints	Community residents and transfer clients complained more often than residents of institutions about difficulties with spouse and/or children.	$p > .001$
Complaints	Community residents and transfer clients complained more often than residents of institutions about poor health.	$p > .01$
Complaints	Community residents and transfer clients reported being lonely more often than did residents of institutions.	$p > .01$
Complaints	Residents of institutions and transfer clients reported feeling abandoned by family more frequently than did community residents.	$p > .001$

(Table G-17 continues on next page)

Table G-17 (continued)

Summary of significant findings

Topic	Finding	Significance Level
Complaints	Female clients more often than male clients complained about a lack of social involvement.	$p > .01$
Complaints	Among community residents, women complained more often than men about aches and pains.	$p > .005$
Termination	Clients with organic brain disorders had their therapy terminated by their therapists more often than clients with other disorders.	$p > .001$
Persistence	Clients with paranoid ideation persisted in therapy longer than clients without paranoid ideation.	$p > .043$
Persistence	Clients with disorders which caused severe discomfort persisted in therapy longer than clients with disorder which caused less discomfort.	$p > .005$
Persistence	Clients who complained about loneliness and social inactivity persisted in therapy longer than other clients.	$p > .001$
Persistence	Clients who reported a positive religious belief and/or religious activity persisted in therapy longer than other clients.	$p > .04$
Persistence	Residents of institutions persisted in therapy longer than community residents.	$p > .002$

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