parliamentary committee on pensions in 1891 and saw social reform as moral uplift and a contributory pension scheme as meeting the needs of the working class. Another major figure was the social scientist Charles Booth, whom Macnicol describes as investigating the health status of the aged and problems of generational equity as well as opening the door to universal public old-age pensions. Macnicol follows the political debate between these poles of contributory and universal pensions, and examines contemporary opposition to pensions coming from the Charity Organisation Society, which favored free-market solutions to social problems, and working-class friendly societies, which included the most skilled workers and desired control of their own limited funds. A crucial turning point came when the friendly societies, joining an increasingly politicized labor movement, dropped their opposition to public pensions.

Macnicol highlights the challenges posed by the First World War, postwar adjustment, the Depression of the 1930s, and the Second World War. The strength of his analysis lies in the history of policy debates. The range is from the New Conservatism of the 1920s and Labor ideas of job redistribution later in that decade to the liberal-centrist program of the research group Political and Economic Planning (PEP), which opposed the socialism of the 1930s, and the feminist contribution of the National Spinsters' Pensions Association (NSPA). But his data on age and employment demonstrate that we are not dealing with a simple linear change. Older men and women moved in and out of the labor market as demographic and economic circumstances evolved. Their work histories, disadvantageously for women, had an impact on pension eligibility and entitlement.

Histories of the welfare state emphasize the contribution of the Beveridge Committee (1941–1942), and Macnicol examines its workings and its Report, which had an impact not only on the 1946 National Insurance Act but also on the way we view the long-term influence of the Second World War on the postwar social and political world. Macnicol provides the long, complex prelude to that development. The "Beveridge Revolution" becomes evolutionary and remarkably conservative. The Report recommended contributory pensions, treated married women as wives rather than citizens, called for modest pension levels, and expressed an ageism rooted in demographic fear (p. 289). Macnicol sheds new light on popular demands for improved state pensions and social policy making in the interwar period. The Labour Party and such pressure groups as the NSPA are presented as having a crucial impact. But all of the activists on pension issues going back to the late nineteenth century are described as never before in the historical literature. Their analysis of social problems and appreciation of political complexities are extraordinarily forward looking.

Macnicol has written a monumental and highly detailed policy history with an explanation from the world of political economy. He does not give us much of the social or cultural life of the retired; however, examples do appear as illustrations of the grand themes. One can also occasionally find individuals in Costa's discussion of her sources, though mainly as illustrations of the information contained within bureaucratic sources. A challenge for future historians of retirement will be to maintain a balance between overarching theoretical issues and the differing perspectives of historical actors. The history of retirement must also be the history of the retired.

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EXPANDING THE PLACE OF GERIATRIC MENTAL HEALTH WITHIN HEALTH SYSTEMS: INTEGRATED CARE, PREVENTION, AND REHABILITATION

Handbook of Aging and Mental Health: An Integrative Approach, edited by Jacob Lomranz. Plenum Press, New York, 1998, 558 pp., $85.00 (cloth).

Handbook of Clinical Geropsychology, edited by Michael Hersen and Vincent B. Van Hasselt. Plenum Press, New York, 1998, 585 pp., no price listed (cloth).

Handbook of the Clinical Psychology of Ageing, edited by Robert T. Woods. Wiley, New York, 1996, 692 pp., $69.95 (cloth).

Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment, by Steven H. Zarit and Judy M. Zarit. The Guilford Press, New York, 1998, 418 pp., $38.95 (cloth).

The Practical Handbook of Clinical Gerontology, edited by Laura L. Carstensen, Barry A. Adelstein, and Laurie Dornbrand. Sage Publications, Newbury Park, CA, 1996, 718 pp., $65.00 (cloth).

As health care continues to evolve, it is important to take stock of current knowledge in geriatric men-

tal health and to develop a perspective on its place within the overall health care of the elderly population. Positive events affecting the field include what appears to be increasing momentum for parity in insurance coverage for mental health relative to general medical services. Negative events include ongoing pressures to increase managed care options in Medicare in a manner that is likely to carve out and decrease the coverage available for mental health care. All of this is superimposed upon the tensions within the mental health field, including concerns about the roles of psychiatry, psychology, and other professions as mental health providers, and about whether Alzheimer's disease should be considered a mental illness as well as a brain disease. What endures despite potential changes and ongoing tensions is the fact that patients with acute mental illnesses only rarely receive appropriate treatment. Moreover, preventive interventions are not available to those at high risk for mental disorders, and rehabilitative services are not offered to those with potentially remediable disabilities.

In our current systems for health care, the most accessible treatments for mental disorders are psychotherapeutic medications. Newer, better-tolerated antidepressant and antipsychotic medications have improved the safety and availability of treatments for depression and psychotic symptoms for elderly patients. In addition, experience with use of acetylcholinesterase inhibitors demonstrates that patients with Alzheimer's disease can experience measurable benefits from treatment. The evidence for the efficacy of these treatments is substantial, and their availability to older persons will increase if President Clinton's June 1999 proposal to make modest pharmacy benefits available to Medicare recipients (or some variant of it) becomes law.

The Breadth of Treatment Modalities

However, the expanding use of psychopharmacological treatment is overshadowing other important treatment modalities. In this context it is important that we ask: What other forms of care are available? The contents of the books reviewed in this essay present perspectives on the nonpsychopharmacological dimensions of mental health care.

Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment, by Steven Zarit and Judy Zarit, is an authoritative and readable book. It provides useful descriptions of the mental disorders of late life together with approaches to their evaluation and psychological treatments in a manner that should serve to build skills as well as knowledge for trainees and developing clinicians. With its focus on diagnosable disorders and evidence-based treatments, the book sets forth a practical view of clinical psychology for elderly adults, implicitly making the case for a core of psychological assessments and interventions that are consistent with medical models for mental health care. In addition, in their chapters on "Coordination of Mental Health and Aging Services," "Family Caregiving," and "Consultation in Institutional Settings," the authors make it clear that the clinical psychology of late life extends beyond the assessment and treatment of diagnosable mental disorders to include the contexts in which these disorders occur, and the importance of other, nonmedical care resources.

The theme that there is more to clinical psychology in late life than approaches to treatment for diagnosable disorders is further emphasized in the other books under review. *The Handbook of the Clinical Psychology of Ageing,* edited by Robert T. Woods, is a comprehensive text or reference book written from a British perspective. In addition to basic chapters on cognitive changes in aging, dementia, and the psychotherapies, it includes chapters on identity management in late life; life events, health, adaptation and social support; the psychology of retirement; bereavement and attitudes to death; sexual functioning in later life; managing sleep and insomnia; family caregiving; the meaning and value of social roles in late life; and elder abuse and neglect.

The Handbook of Clinical Geropsychology, edited by Michael Hersen and Vincent B. Van Hasselt, is also an advanced text or reference volume. It expands the usual scope of psychological services for specific disorders with chapters on conditions that are often neglected when they occur in older persons, including substance abuse, personality disorders, and mental retardation. In addition, it includes general chapters on the value of behavioral perspectives and behavioral medicine interventions, as well as chapters on pain management, retirement, bereavement, marriage and divorce, family caregiving, psychological aspects of physical activity, and elder abuse.

The Handbook of Mental Health and Aging, edited by Jacob Lomranz, is a very different type of book. It is essentially an anthology of chapters intended to "present the state of knowledge, research, and integrative attempts toward theory construction in cogent areas of mental health and aging" (p. 1). Although there are chapters that present conceptual models related to depression and dementia, the content of the volume goes significantly beyond the specific mental disorders. One section deals with a series of theories that relate stresses of diverse types to psychopathology. Another includes chapters on adjustment, resilience, well-being, and growth. Still another section deals with the developing self, psychodynamics, and the family in late life. A recurring theme is the emphasis on narrative as a means for understanding the subjective experience of aging and psychopathology, and for understanding the self.

Finally, *The Practical Handbook of Clinical Gerontology,* edited by Laura L. Carstensen, Barry A. Edelstein, and Laurie Dornbrand, is meant to be useful to practitioners from multiple disciplines who work with elderly patients. The breadth of the material on the mental health and behavioral aspects of aging demonstrates that these areas are central to the overall care of the elderly population. Relevant chapters include those on dependency, maintaining well-being in caregivers, decision making, psychological manifestations of physical disease, and rehabilitation, as well as those on

the psychiatric and medical illnesses that are common in late life. This text makes it clear that mental health issues are of central concern in the care of elderly persons for two complementary reasons—because the brain, mind, and spirit are among the most vulnerable systems in the body, and conversely, because psychological factors can be critical in compensating for physical decline.

The conclusions that must be drawn from these books are that (a) mental health and aging is a broad field, (b) psychotherapy is efficacious and deliverable for mildly or moderately depressed patients, and (c) there is extensive knowledge about coping mechanisms and about the problems, as well as the disorders, that are often experienced by older adults.

Toward the Integration of Care

How does all of this fit into systems for the delivery of health care? The components of gerontological psychology that can most easily be applied are those related to the diagnosis and treatment of discrete mental disorders. The most traditional paths for entering mental health care are through referral to providers by primary care physicians, other practitioners, and families or, less commonly, through help-seeking directly initiated by patients. There are, however, significant patient-, provider-, and system-related barriers to referral that limit the availability of mental health services for older adults. One way to document the importance of this problem is by referring to the intensity of research that is being conducted to develop and validate models for making care more avail-able.

In one initiative supported by the National Institute of Mental Health, called the Prospective Suicide Prevention Collaborative Trial (PROSPECT), investigators form Cornell, the University of Pittsburgh, and the University of Pennsylvania are testing a promising model for the systematic approach to the recognition and treatment of late life depression in the primary care setting. The intervention being evaluated provides education to primary care doctors, screening for depression in their patients, and augmentation of their practices with nurse or psychologist health specialists who follow depressed patients collaboratively with the physician to ensure the delivery of on-time, on-target care for depression, adhering to guidelines developed by the Agency for Health Care Policy and Research. A comparison intervention in this study includes only education and screening. The specific treatments delivered include antidepressant medications complemented with interpersonal psychotherapy as a second-line treatment.

A related series of projects, supported by the Substance Abuse and Mental Health Services Administration and the Department of Veterans Affairs, is also focused on integrated care, comparing it to referral care for late-life depression, anxiety, and alcohol abuse in multiple sites across the country. Although the individual sites differ in the models of care and in the nature of the specific treatments that will be delivered, the study is designed to evaluate the effectiveness of methods for providing mental health care in a manner that is integrated with general medical services within the primary care setting versus those that require referral to separate offices or systems.

Finally, the Hartford Foundation is supporting another multisite study that is comparing integrated delivery with usual care. The intervention package for depression in the elderly persons being evaluated in this study includes screening, education, and care management to ensure algorithm-adherent use of antidepressant medications and brief, structured psychotherapy delivered in the primary care setting.

Thanks to these converging initiatives, a body of evidence sufficient to guide practice and policy with respect to the treatment of the mental disorders that are common in older primary care patients should be available within three or four years. All of these studies are based upon the premise that mental health care is an important part of overall health care for older persons, and that there is a need for decreasing the barriers that primary care patients face in entering treatment. Integration and co-localization of mental health and general medical care have a high degree of face validity and appeal. However, it is important to recognize the challenge involved in developing models that allow integration without compromising the availability of specialized expertise and experience that characterizes referral care. Other evolving challenges may be to maintain integrated models in the face of the financial disincentives present in most managed care programs.

In fact, the most realistic approaches to care may be neither pure integrated nor pure referral models but two-stage models in which care for patients with relatively uncomplicated, common disorders of mild to moderate severity receive first-line treatments within integrated primary care models while other more complex, severe, or unresponsive patients are referred to specialty care. Although much of the ongoing research in this area utilizes pharmacotherapy as the first line treatment for depression, this may reflect logistics and the relative ease of delivering these treatments rather than evidence-based decisions about the relative effectiveness of pharmacological and psychosocial treatments. An alternative model, consistent with the material presented in these books, would be integrative care that brings psychotherapists into the primary care setting to offer interpersonal, brief psychodynamic, cognitive-behavioral, or problem-solving therapies as first-line treatments for those with depressions of mild to moderate severity.

Incorporating evidence-based psychological interventions for diagnosable mental disorders into the health care system is easy, at least conceptually. The more difficult questions are about the utility of the wider view of mental health and aging. Some areas such as pain management, smoking cessation, and behavioral strategies for coping with disease-related changes in sexual functioning can easily fit into specialty niches in health care systems. But there are ongoing questions about insurance reimbursements in these areas, both within standard indemnity Medicare and managed Medicare programs where mental and behav-

ioral health services not directly related to specific mental disorders can fall between the cracks.

Even more difficult are questions about the appropriate place for services designed to improve resilience and to facilitate coping with the multiple changes and losses that occur in aging, or about strategies that focus on problems such as disability, retirement, bereavement, caregiving, and family issues. One point of view might be that these issues are not directly related to health care. Perhaps they belong within the broad array of complementary and alternative treatments that may improve well-being and the quality of life, even if they do not have direct effects on diagnosable disorders. Although complementary and alternative treatments are widely used, they are financed almost entirely through out-of-pocket payments by consumers. The lack of third-party reimbursements severely limits the availability of these treatments to the most poor and most vulnerable of people. Moreover, within this domain of care, there are few indicators or guidelines about what types of interventions are established, efficacious, and safe. Thus, patients and their families may benefit from a broader role for mental health services within health care, but the field must first develop models for delivering care and provide evidence that they are effective.

Prevention and Rehabilitation

Our extended knowledge about mental health in late life may be most applicable in the areas of prevention and rehabilitation. The general stress *diathesis model* presented by Gatz (1998) suggests that interventions designed to enhance coping and stress tolerance should be of value in preventing depression and related conditions in vulnerable individuals. Such strategies would be important to patients, families, providers, payors, and policy makers, not just because depression implies suffering, but in addition, because it amplifies the medical morbidity, disability, service utilization, and even the mortality associated with many other medical conditions. Here, defining the stressors that are most salient for depression appears straightforward; they include illnesses and losses that may occur as discrete events (e.g., cardiac surgery, hip fracture, stroke, or bereavement) or as ongoing conditions (e.g., disability, dependency, social isolation, or a perceived loss of familial or societal roles). The first step in defining vulnerability may also be straightforward, at least for planning research. Given increasing evidence that depression is most often an episodic-recurrent disorder, preventive interventions may be most useful in asymptomatic individuals with a history of depression who are facing significant medical events or other losses.

The implementation of research designed to develop and validate such targeted approaches to prevention must be a high priority. The longer-term vision may be that two-stage integrated-referral models for mental health care should be expanded to include another level of low-intensity/high-availability services that can serve a preventive function. The hope must be that evidence in support of this model will become available and that payors will be persuaded by it.

There are precedents for third-party payment for such low-intensity/high-availability mental health services outside of health care systems. Employers are increasingly recognizing that stress, problems in living, and subthreshold symptoms of anxiety and depression can interfere with workers' productivity. Accordingly, employee assistance programs have become available to provide access to limited services for problems that may not warrant more formal mental health care. Given the high prevalence of parent care responsibilities among working adults and the extent to which they may interfere with productivity, aging-related services such as counseling for caregivers are important parts of many programs. There is a need to disseminate information about the menu of aging-related services available within these programs and to evaluate their impact, both on workers' productivity and on a wider array of outcomes.

Employee assistance programs also provide a precedent that could support funding for low-intensity/high-availability preventive mental health services for the elderly population when they are of economic benefit to payors even when the services may not be directly medical. Clearly there is economic value to enhancing the ability of elderly individuals to live independently within the community. In addition to the elderly persons themselves and their families, stakeholders in maintaining independence include the state and federal agencies that pay for major components of long-term care for the elderly population. Here, the finding that a low-intensity, caregiver-focused intervention can delay nursing home placement for patients with Alzheimer's disease (Mittelman, Ferris, Shulman, Steinberg, & Levin, 1996) should translate into societal investments in mental health and behavioral interventions that maintain independence. The stakeholder, here, is not Medicare but Medicaid, with its financial responsibilities for long-term care in nursing homes. Hopefully, an increasing emphasis on community-based programs for long-term care could make such services more widely available.

The conceptual models leading to preventive interventions are likely to be based upon general principles of stress and adaptation, loss and compensation, or behavioral strategies for coping with specific problems rather than upon the clinical features of specific mental disorders. Programs of prevention may require the application of the basic principles of gerontological psychology and problem-based interventions that complement the role of disorder-based strategies in the treatment of established illness. There may also be a place for application of the broader view of mental health services within the domain of rehabilitation.

Patients with late-life depression as a rule come for treatment of mood disorders that occur in the context of problems such as isolation, difficulties with social supports, or the maintenance of day-to-day functioning in the face of medical illness. Although psychotherapies may target both the symptoms of mood disorders and concurrent problems, pharmacotherapies specifically target disorders. With alleviation of their

depressive symptoms, patients may be more able to mobilize their own resources to solve the problems that compromise their functioning, regardless of the nature of their treatment.

However, we have no estimate of the extent to which this occurs, nor do we have models about how to intervene when residual problems remain after complete or partial remission of symptoms. This situation appears to be similar to contexts where there are problems in ambulation after orthopedic surgery, incontinence after urological procedures, or deconditioning after recovery from severe, prolonged illness of any type. In each of those cases, rehabilitative interventions that target impairments affecting functioning rather than specific illnesses are often medically necessary. By analogy, rehabilitation efforts that target difficulties in role performance, social functioning and self-care that persist after acute treatments for depression may be also medically necessary to help patients remain independent. Thus, rehabilitation may present a context for problem-based interventions in the overall care of elderly patients with late-life mental disorders. Again, there is a need for research to develop interventions and to determine if they have an impact on functioning and independence that would convince health care systems and payors to make these services available.

To summarize, ongoing research is developing models for the interactions of primary medical care with those components of mental health care that are related to the evaluation and treatment of specific disorders. However, inspection of the topics covered in the books reviewed in this essay demonstrates that its role in the treatment of diagnosable mental disorders is only a component of an overall view of mental health care. Some components of an expanded view of mental health should be viewed as basic psychological science that may not have direct applications in health care. Other components, including general principles of coping and adaptation as well as problem-specific knowledge, may be critical in developing preventive and rehabilitative interventions. In fact, the most important role for an expanded view of mental health in the aged within health care may be related to its potential application in prevention and rehabilitation.

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MODELS OF AGING: ADVANCES AND HOPE

Changes in Sensory Motor Behavior in Aging, edited by Anne-Marie Ferrandez and Normand Teasdale. North-Holland, Amsterdam, Holland, 1996, 391 pp., $147.00 (cloth).

Cognitive Decline: Strategies for Prevention, edited by Howard M. Fillit and Robert N. Butler. Oxford University Press, New York, 1997, 138 pp., no price listed (cloth).

The Neuropsychology of Aging, by Diana S. Woodruff-Pak. Blackwell Publishers, Malden, MA, 1997, 352 pp., no price listed (cloth).

I remember a statement Carl Eisdorfer made at a conference a number of years ago on memory assessment. He said that a mature and vibrant medical center is marked by experienced and knowledgeable clinicians to care for patients, researchers to create new knowledge to address pressing basic and clinical issues, and clinicians and researchers forming synergistic relationships that bridge the everyday world and the laboratory. Carl may not remember making such a statement. However, the statement impressed me sufficiently to guide my thinking on not only the maturing of medical or gerontology centers, but also the evolution and development of our science of gerontology.

Let me develop this idea of the maturing of a discipline. Some of the signs for the maturing of gerontology are our ability to: (a) describe aging phenomena; (b) posit, test, and confirm hypotheses of aging mechanisms; (c) apply our findings to clinical and everyday situations to improve older persons' quality of life; and (d) bring everyday and clinical issues to the laboratory as well as use the laboratory to address and understand aging-related issues in the context of everyday life. Over a period of about 60-years, it is fair to state that the science of gerontology has evolved through these steps. While much remains to be understood, one of the greatest challenges, in my opinion, is the bridging of theory and practice to make a difference in the quality of life for older individuals.

I believe the books reviewed in this essay can make a difference in bridging "lab and life" for the older adult. Issues and findings in all three books are directly relevant to the everyday life of an older individual. Specifically, the three books address two of the most pertinent complaints or age-related changes in old age: lower memory ability and loss of energy (Lowenthal et al., 1967). Older adults frequently ask whether the memory decline is normal or, because of the extant publicity on Alzheimer's disease, a preview of hopeless mental and intellectual deterioration. Unless we have a good understanding of the relationship between the brain and behavior, as well as normal and