Prevalence of mental disorders in elderly people: the European MentDis_ICF65+ study

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Background
Except for dementia and depression, little is known about common mental disorders in elderly people.

Aims
To estimate current, 12-month and lifetime prevalence rates of mental disorders in different European and associated countries using a standardised diagnostic interview adapted to measure the cognitive needs of elderly people.

Method
The MentDis_ICF65+ study is based on an age-stratified, random sample of 3142 older men and women (65–84 years) living in selected catchment community areas of participating countries.

Results
One in two individuals had experienced a mental disorder in their lifetime, one in three within the past year and nearly one in four currently had a mental disorder. The most prevalent disorders were anxiety disorders, followed by affective and substance-related disorders.

Conclusions
Compared with previous studies we found substantially higher prevalence rates for most mental disorders. These findings underscore the need for improving diagnostic assessments adapted to the cognitive capacity of elderly people. There is a need to raise awareness of psychosocial problems in elderly people and to deliver high-quality mental health services to these individuals.

Declaration of interest
None.

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In 2010, 16.2% of the world population consisted of people aged 65 or over, a figure that is expected to rise to 26.9% by 2050.1 Increasing life expectancy highlights the importance of physical and mental health in old age.2 Previous studies have generated very inconsistent findings about the prevalence of mental illness among older adults,3,4 although most studies report decreased prevalence rates in advanced age.3,5,6 Studies have tended to focus on selective disorders such as dementia7 or depression,8–10 implying that the entire range of mental disorders has been insufficiently addressed.9 Previous studies using different study designs have found lifetime and current prevalence rates of mental disorders in elderly people ranging from 1 to 18%.9,11 Studies of bipolar disorder, anxiety disorders and alcohol disorders based on structured and standardised assessment instruments such as the Composite International Diagnostic Interview (CIDI)12 are scarce.9 Currently prevalence estimates for depression – the only disorder that is examined consistently – are approximately 3%.9 A few studies report lifetime prevalence rates of substance-related (in particular alcohol-related) disorders in people 65 years and over ranging from 1 to 12%; for schizophrenia, schizotypal disorders and other psychotic disorders, the lifetime and current rate is estimated at 0.5–1.0%, respectively.9 Rates for anxiety disorders vary between 0.9 and 6.7%.9 Only one study used the CIDI to evaluate somatoform disorders in elderly people13 and found a current prevalence rate of 18.4% (participants were 66 over ranging from 1 to 12%; for schizophrenia, schizotypal disorders and other psychotic disorders, the lifetime and current rate is estimated at 0.5–1.0%, respectively.9 Rates for anxiety disorders vary between 0.9 and 6.7%.9 Only one study used the CIDI to evaluate somatoform disorders in elderly people13 and found a current prevalence rate of 18.4% (participants were 66

Method
Participants
The MentDis_ICF65+ study is a cross-sectional multicentre survey20 and the protocol has been previously reported.20 The selection of different catchment areas and countries was balanced according to geographical and socioeconomic population distribution in Europe. Southern European regions of Ferrara (Italy) and Madrid (Spain) were selected as well as London and Canterbury (England) for northern Europe and Hamburg (Germany) for central Europe. The sample further consisted of European Union (EU)-associated regions including Jerusalem (Israel) and Geneva (Switzerland). A random sample of n = 3142 older men and women (65–84 years) living in selected catchment community areas of each participating country (at least 500
participants from each country) stratified by age and gender was
drawn from the population registries in Hamburg and Ferrara
and from postal addresses of market research units in Madrid,
Geneva, London/Canterbury and Jerusalem. Inclusion criteria
for participating in the study included the ability to provide
informed consent, having residence in the predefined catchment
area at the beginning of the study, and being at least 65 and less
than 85 years old. Potential participants were excluded on the
basis of moderate cognitive impairment as assessed by the Mini-
Mental State Examination (MMSE; cut-off score > 18)\(^{21}\)
or an insufficient level of corresponding language. A harmonised
procedure in contacting each participant and conducting the
survey was realised, including initial contact by phone and
mail, standardised interviewer training, implementation of a
standardised study protocol for all test centres, and using
stringent, high-quality data-control procedures.

The response rate was defined as the total percentage of
participants who completed interviews in the study compared
with who were contacted with a written invitation letter.\(^{22}\) In most
of the study centres, a written invitation letter was followed by a
phone call to ask potential participants if they were willing to take
part in the study. As a result of ethical regulations in some
countries, potential participants had to write back to indicate their
interest in participating; phone calls were not acceptable. The
response rates varied by country, age and gender. Responder
analyses showed significant differences in the response rate
between the centres (\(P < 0.001\)) and age groups (\(P < 0.001\)) but
not between genders (\(P = 0.738\)). The age effect indicates that
the response rate was significantly higher for younger participants
than for older participants. The overall response rate of our study
was 20%, which is comparable with that of previous studies with
similar recruitment procedures.\(^{23}\) Furthermore, representativeness
analysis showed that the differences were small between the
catchment areas in our study compared with catchment areas of
the overall population of the participating countries with regard
to sociodemographic characteristics (such as work status, marital
status and education) according to the effect sizes by Somers’ \(d\)\(^{24}\)
(all \(d < 0.01\)); however, these differences were significant because
of the large size of the databases. Furthermore, the minor
differences that were identified are not clinically relevant.

The interview covers a wide range of mental health problems
such as anxiety disorders, affective disorders, psychotic symptoms,
obsessive–compulsive disorder, substance misuse, somatoform
disorders and acute and post-traumatic stress disorders. Cognitive
impairment, somatic morbidity and the use of healthcare services
were also assessed. The instrument also provides differential
diagnoses for mental disorders because of general medical
conditions.

### Statistical analyses

Survey analyses were weighted according to the number of
inhabitants in each country and stratified by gender and two
age groups: 65–74 years old and 74 years or older. The adjusted
lifetime, 12-month and current prevalence rates and 95% confidence limits were estimated as marginal means from a
weighted logistic regression adjusting for age in 5-year intervals,
gender and test centre.\(^{27}\) Group differences were tested using the
main effect \(P\)-value of the model. Odds ratios (OR) and 95% confidence limits were also reported. All analyses were computed
using Stata 12.1.

### Results

#### Sample characteristics

The mean age of the \(n = 3142\) MentDis\_ICF65+ participants was
73.7 years after stratification (\(s.d. = 5.6\)), and half of the sample
was female (50.7%). Participants had attended school for a mean
of 10.3 years (\(s.d. = 3.2\)). The majority of participants were
married (61%), 35% were separated, divorced or widowed and
5% had never been married (Table 1). Approximately 85% of
participants were retired. About half of the participants rated their
financial situation as good or very good (55%), with 8% rating it
as poor or very poor.

#### 12-month and lifetime prevalence

One in two individuals aged 65–84 years had experienced a
mental disorder in their lifetime (Table 2). About one-third of
the sample had a mental disorder within the past year (35.2%,
95% CI 31.0–39.5) (Table 3). There were significant differences
between centres for all mental disorders in the past year except

#### Measures

CIDI adaptation process, structure and training

Mental disorders were diagnosed with an adapted, age-sensitive
version of the CIDI, the CIDI65+.\(^{25}\) This fully structured lay
interview generates diagnoses according to DSM-IV criteria.\(^{19}\)
The process of adapting the test to the unique conditions of
elderly people included several facets, including adding words,
alternative questions and detailed section introductions, breaking
down long questions into less complicated questions, sensitising
scales upfront and embedding a fuller spectrum of syndromes.
The English paper and pencil version was translated into German,
Spanish, Hebrew, Italian and French with a back-translation and
then computerised. A pre-testing phase was conducted in
Germany and the UK to evaluate feasibility and verify the
acceptability of the CIDI65+ to respondents. To evaluate the
usability and reliability of the CIDI65+, a pilot phase was
conducted.\(^{25}\) Overall, the results on the reliability of the CIDI65+
were good for most diagnoses (such as depression (\(k = 0.79\)) and
anxiety disorders (\(k = 0.69\))). Lower \(k\)-scores were found for less
frequent disorders such as panic disorders (\(k = 0.37\)), similar to
other diagnostic instruments that also report lower reliability
scores\(^{26}\) or that have classification systems that are less precise.\(^{25}\)

| Table 1 Demographic characteristics of the participants |
|-----------------------|-----------------------|
| Demographic characteristic | Total sample |
| Age, n (%) | |
| 65–74 years | 1715 (54.6) |
| 75–84 years | 1427 (45.4) |
| Gender, n (%) | |
| Women | 1592 (50.7) |
| Men | 1550 (49.3) |
| Education, years of schooling (cut-off 13 years): mean (s.d.) | 10.3 (3.2) |
| Marital status, n (%) | |
| Married | 1915 (61.0) |
| Separated/divorced/widowed | 1082 (34.5) |
| Never been married/other | 142 (4.5) |
| Work status, retired: n (%)\(^a\) | 2640 (84.6) |
| Financial situation, n (%)\(^b\) | |
| Very good | 356 (11.4) |
| Good | 1372 (43.8) |
| Just enough | 1145 (36.6) |
| Poor | 219 (7.0) |
| Very poor | 37 (1.2) |

\(^a\) n = 3128

\(^b\) n = 3142

https://doi.org/10.1192/bjp.bp.115.180463 Published online by Cambridge University Press
### Table 2: Lifetime prevalence rates of frequent mental disorders

<table>
<thead>
<tr>
<th>Affective disorder</th>
<th>Hamburg (Germany)</th>
<th>Ferrara (Italy)</th>
<th>London (England)</th>
<th>Madrid (Spain)</th>
<th>Geneva (Switzerland)</th>
<th>Jerusalem (Israel)</th>
<th>Over all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive episode</td>
<td>11.6 (9.5–13.7)</td>
<td>9.2 (6.5–12.0)</td>
<td>14.6 (11.4–17.8)</td>
<td>10.5 (8.3–15.7)</td>
<td>23.3 (19.3–27.4)</td>
<td>14.8 (10.7–18.9)</td>
<td>11.8 (9.7–14.0)* ***</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>2.5 (1.4–3.6)</td>
<td>3.1 (2.1–4.1)</td>
<td>3.4 (2.6–4.2)</td>
<td>2.5 (1.6–3.5)</td>
<td>4.0 (2.6–5.4)</td>
<td>5.2 (3.5–6.8)</td>
<td>2.9 (2.3–3.5)*</td>
</tr>
<tr>
<td>Any bipolar disorder</td>
<td>4.7 (3.2–6.2)</td>
<td>2.4 (1.4–3.5)</td>
<td>4.2 (2.9–5.5)</td>
<td>6.9 (4.0–9.7)</td>
<td>30.0 (22.3–37.7)</td>
<td>61.1 (43.8–74.0)</td>
<td>4.8 (3.3–5.5)*</td>
</tr>
<tr>
<td>Any affective disorder</td>
<td>13.2 (10.9–15.4)</td>
<td>11.9 (9.5–14.4)</td>
<td>18.0 (14.9–21.1)</td>
<td>13.0 (7.8–18.3)</td>
<td>26.5 (22.5–30.5)</td>
<td>18.5 (12.3–24.6)</td>
<td>14.3 (12.0–16.6)** ***</td>
</tr>
</tbody>
</table>

#### Anxiety

| Any simple phobia | 15.7 (12.7–18.6) | 11.6 (9.3–14.0) | 21.2 (17.3–25.2) | 21.5 (16.4–26.7) | 15.3 (13.0–17.5) | 14.9 (11.8–17.9) | 16.7 (13.4–20.1)** *** |
| Any anxiety disorder | 24.1 (21.1–27.0) | 20.1 (16.5–23.7) | 32.6 (27.1–38.1) | 29.3 (23.9–34.8) | 20.7 (16.6–24.8) | 21.3 (16.3–26.6) | 25.6 (21.4–29.7)** *** |

#### Substance misuse

| Alcohol dependence or misuse | 12.9 (9.8–16.1) | 1.7 (0.9–2.4) | 13.8 (10.5–17.1) | 3.8 (1.5–6.1) | 14.1 (9.5–18.8) | 3.2 (2.4–3.9) | 8.8 (4.5–13.2)** *** |
| Any substance-related disorder | 21.3 (18.1–24.6) | 12.9 (10.6–15.2) | 20.6 (17.1–24.0) | 16.3 (123–203) | 21.8 (16.6–26.9) | 12.8 (10.9–14.6) | 18.2 (14.6–21.8)** *** |

#### Any mental disorder

| Any somatoform disorder | 9.2 (7.4–11.0) | 5.9 (3.6–8.2) | 9.4 (7.2–11.5) | 3.5 (2.1–4.8) | 7.7 (6.6–8.8) | 10.7 (9.3–12.0) | 7.5 (5.7–9.3)** *** |
| Any mental disorder | 47.0 (44.1–49.9) | 38.8 (34.3–43.3) | 56.3 (49.7–63.2) | 46.3 (41.6–51.0) | 55.7 (53.5–58.0) | 46.0 (42.0–50.1) | 47.0 (42.8–51.3)** *** |

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### Table 3: Twelve-month prevalence rates of frequent mental disorders

<table>
<thead>
<tr>
<th>Affective disorder</th>
<th>Hamburg (Germany)</th>
<th>Ferrara (Italy)</th>
<th>London (England)</th>
<th>Madrid (Spain)</th>
<th>Geneva (Switzerland)</th>
<th>Jerusalem (Israel)</th>
<th>Over all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive episode</td>
<td>11.1 (9.1–13.2)</td>
<td>9.1 (6.4–11.8)</td>
<td>14.5 (11.5–17.4)</td>
<td>10.3 (5.3–15.3)</td>
<td>23.1 (18.9–27.4)</td>
<td>14.6 (10.3–18.9)</td>
<td>11.6 (9.5–13.8)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>2.5 (1.4–3.6)</td>
<td>3.1 (2.1–4.1)</td>
<td>3.4 (2.6–4.2)</td>
<td>2.5 (1.6–3.5)</td>
<td>4.0 (2.6–5.4)</td>
<td>5.2 (3.5–6.8)</td>
<td>2.9 (2.3–3.5)*</td>
</tr>
<tr>
<td>Any bipolar disorder</td>
<td>2.1 (0.3–4.0)</td>
<td>1.2 (0.3–2.2)</td>
<td>2.9 (1.8–5.0)</td>
<td>4.9 (2.1–7.6)</td>
<td>1.2 (0.3–2.2)</td>
<td>4.7 (3.0–6.5)</td>
<td>2.5 (1.3–3.7)*</td>
</tr>
<tr>
<td>Any affective disorder</td>
<td>12.7 (10.6–14.8)</td>
<td>11.1 (8.5–13.6)</td>
<td>17.6 (14.7–20.4)</td>
<td>12.4 (7.7–17.0)</td>
<td>25.7 (21.2–30.3)</td>
<td>17.8 (12.2–23.3)</td>
<td>13.7 (11.4–15.9)** ***</td>
</tr>
</tbody>
</table>

#### Anxiety

| Any simple phobia | 9.1 (7.3–10.9) | 6.8 (5.8–8.1) | 9.4 (6.1–12.7) | 12.7 (9.4–16.1) | 9.2 (7.4–11.1) | 8.9 (7.1–10.6) | 9.2 (7.2–11.1)* |
| Any anxiety disorder | 16.8 (14.4–19.2) | 14.4 (11.6–17.3) | 20.8 (15.6–26.0) | 18.3 (14.4–22.3) | 14.1 (10.4–17.8) | 14.7 (10.7–18.7) | 17.2 (14.0–20.4)* |

#### Substance misuse

| Alcohol dependence or misuse | 7.4 (5.3–9.2) | 1.0 (0.3–1.5) | 9.5 (6.4–12.6) | 1.3 (0.4–2.2) | 9.1 (5.7–12.5) | 12.0 (7.2–17.8) | 5.3 (2.3–8.2)** *** |
| Any substance-related disorder | 11.2 (9.7–12.7) | 5.8 (5.1–10.2) | 11.2 (6.2–16.1) | 5.6 (3.5–7.6) | 12.7 (9.4–15.9) | 37.2 (26.4–47.9) | 8.9 (6.1–11.7)** *** |

#### Any mental disorder

| Any somatoform disorder | 4.8 (4.0–5.7) | 2.7 (1.3–4.2) | 5.3 (3.0–7.6) | 2.5 (1.3–3.8) | 3.7 (3.0–4.5) | 8.4 (5.4–11.5) | 4.1 (3.1–5.1)* |
| Any mental disorder | 35.4 (33.2–37.6) | 27.7 (21.1–34.4) | 44.4 (39.5–49.3) | 32.2 (29.1–35.3) | 47.1 (44.4–49.9) | 36.7 (33.0–40.4) | 35.2 (31.0–39.5)** *** |

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a. Rates are adjusted for age and gender and accompanied by 95% confidence intervals.

*P<0.05, **P<0.01, ***P<0.001.

https://doi.org/10.1192/bjp.bp.115.180463 Published online by Cambridge University Press

Prevalence of mental disorders in elderly people.
Current prevalence

Current prevalence rates are shown in Table 4. Nearly a quarter of the sample were diagnosed with any current mental disorder (23.3%, 95% CI 19.9–26.7) with the highest prevalence rates found in Geneva (30.4%), London/Canterbury (28.4%) and Jerusalem (27.0%). Lower prevalence rates for any current mental disorder were found in Hamburg (23.3%), Madrid (21.0) and Ferrara (19.5%).

The most prevalent category was anxiety disorders (11.4%, 95% CI 9.1–13.6), followed by affective disorders (8.0%, 95% CI 6.3–9.6) and substance-related disorders (4.6%, 95% CI 3.7–5.6). Elderly participants living in London/Canterbury or Hamburg had the highest prevalence rates for anxiety disorders in the past month (England: 13.4%, 95% CI 10.2–16.5; Germany: 12.0%, 95% CI 10.1–13.8). In contrast, elderly people living in Ferrara and Geneva had the lowest current prevalence rates for anxiety disorder within the past year (Switzerland: 12.7%, 95% CI 9.4–15.9), Hamburg (11.2%, 95% CI 9.7–12.7) and London/Canterbury (England: 11.2%, 95% CI 6.2–16.1). The lowest prevalence rate for substance-related disorders was found in Jerusalem (3.7% (Israel: 95% CI 2.6–4.7) (Table 3).

Main findings

Studies of mental disorders that do not focus on dementia or depression among elderly Europeans are very scarce. This is the first study to use a standardised and structured clinical interview for mental disorders adapted to the needs of elderly people to report lifetime, 12-month and current prevalence rates for a range of disorders that might be relevant for health policy. The most prevalent disorders were anxiety and affective disorders, followed by substance use and somatoform disorders. Lower rates were found in London/Canterbury and in Madrid (Spain: 5.0% (95% CI 4.2–7.5)) (Tables 2 and 3). Elderly people in Geneva reported the highest prevalence rate for affective disorder within the past year (Switzerland: 12.7%, 95% CI 10.6–14.8), Madrid (Spain: 12.4, 95% CI 7.7–17.0) and Ferrara (Italy: 11.1, 95% CI 8.5–13.6). The highest prevalence rates for substance-related disorders were found in Geneva (Switzerland: 12.7%, 95% CI 9.4–15.9), Hamburg (11.2%, 95% CI 9.7–12.7) and London/Canterbury (11.2%, 95% CI 6.2–16.1). The lowest prevalence rates for substance-related disorders was found in Jerusalem with 3.7% (Israel: 95% CI 2.6–4.7) (Table 3).
of mental disorders in elderly people residing in different European and associated countries. One in two individuals aged 65 to 84 years had experienced at least one mental disorder in their lifetime, one in three had done so within the past year, and nearly one in four currently had a mental disorder. The most prevalent disorders were anxiety disorders, followed by affective and substance-related disorders.

Comparison with findings from other studies
In comparison with other epidemiological studies of old age and adulthood that used standardised interviews such as the CIDI, our findings show higher prevalence rates, whereby the proportion of those affected is in accordance with the prevalence rates in adulthood. Compared with other studies on old age, we found higher current prevalence rates of major depression (6% in our study vs. 3.3%), agoraphobia (3.4% vs. 0.5%) and alcohol disorders (1.4% vs. 0.9%). There was only one European study from the 1990s that found comparable rates for current affective disorders, which also used an age-sensitive measure for depression. It is plausible that previous epidemiological studies underestimated the prevalence rates of mental disorders in elderly people because they did not use an interview adapted to meet concerns specific to elderly people. The sentences in the CIDI65+ were changed to make them easier for elderly people to understand and respond to, and this may have contributed to more valid estimates of mental disorders. Another reason for the higher prevalence rates in our study could be that all countries used the same methodological approach, whereas previous studies may have underestimated prevalence through use of different instruments and possible measurement errors. Another important point to consider is the use of categorical v. dimensional instruments. There is an explicit difference in prevalence rates obtained with dimensional and categorical instruments in affective disorders. Our study builds on established categorical criteria for mental disorders as defined by the DSM-IV. However, due to the multidimensional nature of psychopathology, the criteria and thresholds of the DSM-IV are not without major problems. Reviews that compare findings for dimensional measures of current psychopathology with categorical current prevalence typically reveal higher rates for dimensional measures that might vary depending on the choice of cut-offs that are used. There is also a possibility that the presented rates are still underestimating the true prevalence of mental disorders in elderly people because we excluded people with severe cognitive impairment from the study.

Prevalence rates in different countries
The prevalence rates found in our study are comparable among the participating countries except for fluctuations in the absolute size. Furthermore, there were several important differences between the six catchment areas. Interpreting those differences is complex because of the large differences between the countries with regard to the availability of mental healthcare, the specific economic situation, immigration status, living circumstances, attitudes towards mental disorders in elderly people, experience of traumatic events and lifestyles. Such factors may be associated with greater or lesser willingness and ability to express psychological symptoms during an interview. Another interesting finding is the marked difference between the rates of substance misuse in the southern areas of Ferrara (Italy), and Madrid (Spain) and the more northern European areas of London/Canterbury (England), Hamburg (Germany), Geneva (Switzerland); these results are in line with previous European studies on substance misuse in adulthood.

Strengths and limitations
An advantage of the current study was the use of a reliable, structured and standardised instrument that was adapted to the needs of elderly people. Trained interviewers assessed participants in catchment areas in Hamburg (Germany), in London/Canterbury (England), Geneva (Switzerland), Madrid (Spain), Ferrara (Italy) and Jerusalem (Israel) face to face according to DSM-IV criteria, and the reliability of the instrument was evaluated beforehand in a pilot phase of the study.

Nevertheless, the study has some limitations. First, the size of the sample was limited per country and per catchment area. Second, the representativeness of our study may be limited because we found small but significant differences for some socio-demographic data between our sample and the total population of the catchment area or country. Third, this study found higher prevalence rates of mental disorders in older people than did previous studies; thus, the question arises of whether the response rate in this study is associated with an overestimation or underestimation of prevalence compared with previous studies. However, previous studies have found both higher and lower prevalence rates of mental disorders in non-responders. Kessler et al. found no evidence for a selection bias related to mental illness in the US National Comorbidity Survey Replication (NCS-R). The authors concluded that to the extent the bias exists, prevalence estimates may be regarded as more conservative. In addition, many authors have stated that non-response can, but need not, automatically mean there is a non-response bias in survey estimates. Therefore, it may also be possible that the prevalence of mental disorders in older people is still underestimated in our study. Furthermore, we were unable to include other important population variables such as educational level or financial situation. Another limiting factor regarding representativeness was our set of inclusion criteria: we did not include people with severe cognitive impairment, homeless people or people who did not have sufficient knowledge of the language in which the interview was conducted. In addition, due to the nature of epidemiological studies with elderly people, we were unable to control for a possible recall bias, especially regarding lifetime symptoms.

Future directions for research
Our study showed a high prevalence rate of lifetime, 12-month and current mental disorders in people aged 65 to 84 years in different European and associated countries. The newly adapted CIDI65+ instrument shows the need for further research in the diagnostics of mental disorders in elderly people, which is a crucial step towards more comprehensive mental health approaches for these age groups. Future studies could investigate the prevalence of mental disorders in even older people (of 85 years and above, as this age group is growing rapidly). However, this group may require additional modifications in diagnostic assessment, as additional challenges are associated with very old age (for example, cognitive impairment). Future European studies could also include more countries, such as those from the Scandinavian or Eastern European regions, and consider including nursing home residents or elderly people with cognitive impairments. Translations into further languages and extensions to surveys in other continents would be a further milestone. In addition, data about somatic diseases and their relationship with quality of life are needed. Additional studies could also integrate...
primary care perspectives into the diagnostics as this is where the majority of older adults with mental health problems are treated; thus, this will enable the general practitioner to give advice on specialised mental healthcare. Finally, further studies should examine whether the use of services corresponds to the high burden of mental illness in elderly people.

**Funding**

This study is funded by a grant from the European Commission (Grant No: 223105) within the 7th Framework Program Research Project of the European Union.

**Acknowledgements**

We gratefully thank all participants and all interviewers in our study.

**References**


37 Groves RM. Nonresponse rates and nonresponse bias in household surveys. Public Opin Q 2006; 70: 646–75.


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‘In The Spirit of Rivers’

Jo McFarlane

When I was 25, a CPN referred me for psychotherapy to cure my personality.

I was assessed and found wanting but my need was so great, and my resilience weak, so how could anybody sensibly take a chance with me?

The litany of traumas I disclosed, like an automaton spitting toxic pellets, didn’t penetrate its target audience.

Did the therapist think I was lying, perhaps? Or was she thrown off guard by the detachment in my voice?

The conclusion was predictable, if, at the time, incomprehensible to me.

(The more help one needs, the less one gets).

Disproportionate equations abound in psychiatry: if you ask for help, you mustn’t need it; but refuse it and you’re certified psychotic so they’ll throw away the key.

Side effects of medication are interpreted as symptoms; blind compliance is a sign you’re in recovery.

Oh would that my brain could shut off so easily! I was sent away to write a sonnet Thank you Doctor for ‘saving the poet!’

Naively, at the age of 36, I thought I’d earned the right to ditch my load, so cap in hand (with money for them) I approached the Institute of Humorous Relations.

My life experience seemed alien and threatening to the middle class arbiter of my fate.

On concluding the assessment, she paused for reflection, then – as though weighing up a bag of cherries in her hand – had the cheek to say ‘Let’s not rock the boat’.

Didn’t she give a damn about the massive hole in the bottom sucking all the water in!

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Through their collection Stigma & Stones, writers/performers/partners Sally Fox and Jo McFarlane seek to promote understanding, improve treatment and reduce the stigma of living with a diagnosis of BPD.