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# An investigation of mental health service utilization by older adults.

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# AN INVESTIGATION OF MENTAL HEALTH SERVICE UTILIZATION BY OLDER ADULTS

A Dissertation Presented

by

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ABSTRACT

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Although the current literature documents the lack of sufficient utilization of mental health services by older adults, there has been a lack of clarity regarding which factors are significant utilization predictors. The goal of this study was to examine a wide array of demographic, external, and internal utilization barriers, as well as to explore the new barriers of treatment fearfulness, self-concealment, aging concerns and memory controllability. A sample of community adults (214 females and 129 males) completed a self-report questionnaire on mental health services. The sample ranged in age from 40 to 91 years ($\underline{M}$ = 58.01, $\underline{SD}$ = 12.27) and was divided into two cohort groups (Baby Boomers and older adults in the Post-War, WWII and Depression cohorts). Four measures of mental health service utilization were used, including past utilization, future likelihood of utilization and two questions regarding how respondents would respond to depressive symptoms. Multiple logistic and linear regression analyses revealed several variables were unique predictors of utilization even when all other significant individual barriers were controlled for. For the Baby Boomers these variable

included: health status, physician visits, knowledge of insurance, depression, therapist responsiveness, self-concealment, and attitudes towards psychotherapy. For the older adult cohort group these variables included: Medicare (having Medicare), the belief in inevitable decline in memory, attitudes towards psychotherapy and knowledge of insurance. Additional variables were significant predictors when tested alone, including gender and the memory controllability subscales for the Baby Boomers, religiosity for the older adult cohort group, and coercion concerns for both cohort groups. Lastly, depressed individuals reported significantly more negative beliefs regarding memory and higher levels of treatment fears than non-depressed individuals. These results suggest that treatment fears and memory controllability are important factors to consider as effecting mental health service utilization. The findings also support the notion that demographic, external, and internal factors have unique impacts on service utilization and vary by cohort group. Research and clinical applications of these findings are discussed in an attempt to help address the needs of the older population in mental health clinical practice, administration and policy.

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# CHAPTER I

# INTRODUCTION

The older adult population has grown rapidly over the past two decades and currently 12.4% of the U.S. population is over the age of 65 (U.S. Bureau of the Census, 2003). Approximately 20% of those over the age of 65 are thought to have a diagnosable mental disorder (Gatz & Smyer, 2001). Many concerns exist in serving this population's mental health care needs, including Medicare's reimbursement of services, education of professionals in providing appropriate care, and the coordination of mental health services with medical care (Jeste et al., 1999; Koenig, George, & Schneider, 1994). These concerns exist for the current cohort of older adults and may become concerns for the middle-aged, or Baby Boomer cohort, as these individuals age. Baby Boomers are the fastest growing segment of the population (U.S. Bureau of the Census, 2003) and based on their lifetime prevalence rate, are predicted to show more mental disorders in old age than any previously born cohort (Jeste et al., 1999). While these concerns and growing demands regarding health care services have received attention in the literature, questions remain about how to ensure that middle-aged and older adults will seek mental health services even when appropriate services and reimbursement are offered.

## Literature Review

In the 1980's, many researchers began to document and report the underutilization of psychological services by those over the age of sixty-five (Krout, 1983; Lasocki & Thelen, 1987; Smyer & Pruchno, 1984; Waxman, Carner, & Klein, 1984). Early studies focused on the rates of psychological disorders in this population and the need for seeking services as compared to the rates of older adults actually seeking treatment. It

was estimated that only 40% of those adults over the age of sixty-five, who were in need of mental health care, received treatment (Shapiro, 1986). In additional research, only 3% of participants over age sixty-five reported seeking mental health services and levels of psychiatric impairment did not predict seeking these services (Smyer & Pruchno, 1984). In a large sample of over 1500 participants, those over the age of 65 were found to be less receptive to considering mental health services than were those in younger groups (Leaf, Bruce, Tischler, & Holzer, 1987). Overall, these findings consistently reflected the trend that older adults were unlikely to seek psychological treatment.

Current studies report some modest improvement in service utilization in recent years (Knight & Kaskie, 1995) but in general, the older adult cohort rate of accessing mental health services is lower than its rate of need (Jenkins & Laditka, 1998; Yang & Jackson, 1998). There have been few new attempts to provide explanations of these patterns. Some studies have presented programs that were successful in attracting and serving older clients (Knight, 1996; Yang & Jackson, 1998) and consistent evidence exists which has shown that those older adults in need of services seek assistance from their medical rather than mental health providers (Arean, Alvidrez, Barrera, Robinson, & Hicks, 2002; Phillips & Murrell, 1994). However, these studies have not produced data on why the programs have been able to recruit older adults or why medical, rather than mental health providers, are more frequently accessed.

Studies providing consistent support for the suggested barriers to service are missing from the literature. In addition, there has been little attempt to integrate the possible contributors to underutilization into a model or to separate those factors that lie within an individual from those on the societal level. This study focused on the factors

suggested by other investigators as sources of underutilization, rather than on the body of literature simply documenting the low rates of mental health treatment use by older adults. In addition, the study focused on outpatient treatment, because services offered on an outpatient basis tend to involve clients seeking care themselves. Much work remains also in addressing the concerns of the older adult inpatient population and in long-term care.

In reviewing the literature, the demographic factors of gender, socioeconomic status and cohort are briefly examined. However, with the exception of age and cohort differences, there has been little effort in recent work to examine the impact these factors have on service utilization. Following the discussion of demographic factors, the external factors suggested to influence utilization are reviewed, followed by the internal factors, such as attitudes towards treatment for older adults. Finally, new internal factors, are considered as possible barriers to seeking treatment. Beliefs about memory control, concerns regarding aging, and treatment fearfulness are introduced as individual factors and examined in terms of their impact on service utilization. The current study investigated both those factors suggested in past research and the role of these new variables in service utilization. The goal of this study was to begin to integrate the barriers to service for older adults by examining multiple barriers within one study and ultimately, to provide more information on older adults' views on mental health services and to assist in better serving the mental health needs of the older population. In addition, the barriers to mental health services were examined in both the middle-aged and older adult populations to examine how these factors may impact each generation's service use.

## Demographic Factors

Here, findings were reviewed which suggest how gender, socioeconomic status, cohort and ethnicity may impact service utilization. However, there has not been sufficient diversity in the literature to suggest that these findings can be generalized to all older adults. There are very few studies on the utilization of services by older adults that use a diverse sample in terms of socioeconomic status, race, or ethnicity. Older ethnic minority adults have not been recruited or included in most studies on geropsychological treatment (Arean & Gallagher-Thompson, 1996). In addition, while in general, women have been found to be more likely to seek services than men, it remains to be seen if this finding applies to older adults. The majority of older adults recruited for research are women, making gender comparisons difficult. Much more work is needed in gathering data on the experiences of more diverse populations, examining gender differences and learning how these factors influence utilization.

From the limited existing research, there is evidence to suggest that gender and socioeconomic status may have an impact on middle-aged adults' service utilization. Leaf, Bruce, Tischler and Holzer (1987) found that socioeconomic status (SES) and gender predicted service utilization. Men and those in lower SES groups were less receptive to treatment than women or those in higher SES groups. Thus, men and members of poorer groups may pursue psychological services at an even lower rate than the rest of the older adult population. No recent studies have attempted to test these trends in older adults.

In terms of ethnicity and SES, there is a paucity of literature which has examined the service use of older adults from various ethnic groups and lower income groups.

There is some literature discussing the difficulties of recruiting ethnic older adults to participate in clinical research and makes recommendations to improve involving these groups (Arean and Gallagher-Thompson, 1996). In addition, Yeatts, Crow and Folts (1992) conducted research in the late 90s which offered suggestions for improving service use for older adults in ethnic and lower SES groups. However, much work remains in exploring the patterns of service use or providing information on which barriers truly predict the utilization of services for these groups.

The most recent study examining ethnicity and mental health services uses data from the National Comorbidity survey (Chamberlain et al., 2001). This study's strength is that it surveyed over 8000 participants; however, the age range was limited from 15 to 54. In this study, African Americans reported more positive attitudes and a higher likelihood of seeking services than Whites, both in the general population and among those with depression. No studies exist at this stage that have examined if these findings are applicable to those over the age of 55. In addition, a recent study with older Mexican Americans, suggested that knowledge about health care services and expectations of discrimination impacts their use of skilled home care (Crist, 2002). It is presumed that these beliefs may impact their views on mental health service utilization as well. However, it is clear that much work remains in further clarifying if these factors are important, especially for older adults.

In the literature on aging, both within psychology and within marketing research, a focus has been placed on comparing attitudes and patterns of utilization of services between cohorts or generations. Cohort refers to the general era or generation in which a person was born. Those born in the same generation are thought to acquire values and

attitudes as a result of the environment and significant events which occurred during the time they came of age (Noble, Schewe, & Kuhr, in press). Six cohorts have been identified and described in the literature. Five of these cohorts make up the middle and older aged groups of the population and have been characterized as follows (Schewe, Meredith, & Noble, 2000): The depression cohort, those born between 1912 and 1921 (ages 81 to 90 today), are characterized by an emphasis on financial security, tend to respect and believe in authority, and attempt to build structure into their lives. Those in the WWII Cohort, born 1922-1927 (ages 75 to 80 today), are characterized by similar values of security and respect for authority, but have more of a sense of independence and possess more romantic ideals from their war experiences. Those in the Post-War cohort, born from 1928 to 1945 (ages 57 to 74), were the beneficiaries of a period of economic growth. They are characterized by conservative beliefs and an emphasis on comfort and security in their lives. The final two cohorts born between 1946 and 1965 (ages 37 to 56) are the Baby Boomers. This group is characterized by an emphasis on individualism, indulgence, self-stimulation and rebellion against authority. They tend to question information and emphasize youth and beauty. The Baby Boomers are split into two cohorts, Boomers I (ages 48 to 56) and Boomers II (ages 37 to 47). These groups tend to be characterized by similar values, although while Boomers I grew up in times of economic growth, the second cohort of Boomers faced a difficult economy. The youngest group is more likely to spend money expecting to go in debt, while the older Boomers tend to spend money while still emphasizing financial security. Marketing research has demonstrated that these differences in values and beliefs result in differences in the expectations and utilization of health care services (Schewe et al., 2000). Thus, the cohort

variable appears to be quite useful for making age group comparisons in terms of mental health services utilization.

Studies documenting underutilization have suggested that cohort differences exist in the likelihood of seeking mental health treatment. These studies indicate that comparisons between cohorts may be more useful in considering differences in utilization than studies which use more arbitrary age groups. Currin, Schneider, Hayslip and Kooken (1998) compared the attitudes of an earlier born cohort sampled in 1977 and later-born cohort sampled in 1991. All participants were between the ages of 60 and 70 at the time of testing. They found that attitudes towards mental health services were more positive in the later-born cohort. This sample had more knowledge regarding mental health services and more positive expectations regarding the effectiveness of treatment. The latter born sample also reported a higher rate of utilization of mental health services. Thus, it may be that attitudes and utilization are improving in each successive generation (Currin et al., 1998). However despite the improvement in the attitudes of the younger cohorts, older adults continue to consume a proportionately smaller percentage of mental health services than do younger individuals (Jenkins & Laditka, 1998).

## External Factors

On a systemic level, Medicare reimbursement of psychological services has been discussed as a powerful contributor to older adults' failure to receive appropriate mental health services. The first concern is that basic Medicare pays 80% of outpatient medical fees but only reimburses 50% of outpatient mental health fees. A substantial number of older adults cannot afford to purchase supplementary private insurance (i.e., Medigap policies), do not qualify for Medicaid insurance (for low income individuals) and

therefore must pay for half of their outpatient mental health services (Jenkins & Laditka, 1998; Norris & Molinari, 1998). Although Medicare has begun to utilize and offer managed care plans to individuals as a way to address these issues, concerns remain about how managed care will affect the quality of services (Norris & Molinari, 1998). Individuals on these plans may be limited in their choice of providers and are required to obtain referrals in order to receive care from specialists, including psychologists. In addition, patients often are denied treatment if the managed care company does not feel it is medically necessary (Burke, 1997). Norris and Molinari (1998) speculate that the system structure of these companies may be a barrier for older adults' seeking treatment. Thus, the diverse needs of this population may not be met by the current health care system.

Medicare policies may also inhibit mental health providers from seeing older patients (Gatz & Smyer, 1992; Koenig et al., 1994). Specifically, Medicare policies set allowable charges at approximately half of the usual fees set for patients with other insurance or for those paying out of pocket. Koenig and colleagues (1994) report "for every Medicare patient the clinician sees, he or she takes a 43%-55% reduction in income" (p. 675). The result of this policy is that many mental health providers limit the number of Medicare patients they are willing to see or refuse to see geriatric patients (Koenig et al., 1994). Without willing and well-trained providers, older adults find themselves limited in treatment options especially in psychotherapy.

Finally, health care reform plans provide incentives for mental health problems to be treated with medication rather than psychotherapy. Older adults who are willing to seek treatment may be encouraged by lower co-payments and unlimited medication

management visits to take medications rather than seek the services of psychologists or social workers (Bartels, Levine, & Shea, 1999). Psychopharmacological treatments present medical risks and may result in frustration on the part of the patient when the medication fails to assist with the patient's true difficulties (Koenig & Breitner, 1990). In addition, recent literature has suggested that older adults may prefer psychotherapy as a treatment option over anti-depressant medication (Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001). To add to the patients' frustration, little communication occurs between the networks providing services to older adults. Physicians, who could serve to refer older adults to appropriate mental health services often do not recognize depressive symptoms or make appropriate referrals. Recent research found that only 27% of surveyed physicians reported that they would refer an older depressed patient for mental health treatment (Arean, Hegel, & Reynolds, 2001). Consequently, medication management may be the only option offered by medical providers and this option may not be appropriately coordinated with other available services (Jenkins & Laditka, 1998). Thus, patients may feel disappointed with treatment options and lost in the maze of different provider networks leading them to avoid seeking mental health services.

Providers' hesitation to take older clients may not be solely the product of Medicare reimbursement. Ageism may serve as an additional barrier. Providers may feel that older adults' symptoms are irreparable and that their problems are too complex for treatment (Lasocki, 1986). Gatz and Pearson (1988) reviewed the literature on the stereotypes of aging clients held by mental health providers. They found that studies using generalized attitude scales failed to document negativity or "ageism" toward older adults, but found many results suggesting providers had multiple stereotypes of older

adults. Stereotypes were divided into clusters of traits ranging from a positive prototype of the "perfect, sage grandparent" (Gatz & Pearson, 1988, pg. 185) to the negative prototype of a senile and despondent individual. While professional ageism was not expressed in overall negative attitudes, providers were more likely to recommend medication than psychotherapy and had poorer prognoses of treatment for older patients. In addition, providers were likely to assume older patients would be demented. Gatz and Pearson concluded that ageism does not account for older adults avoiding treatment; however, they suggested that educating psychologists to recognizing the differences between normal aging and dementia is crucial in improving psychologists' ability to serve the older population.

In the past ten years, an effort has been made to inform providers about making appropriate diagnoses and providing adequate treatment for older adults. Several organizations have formed which specifically address the clinical issues of older adults and have attempted to define standards of care for those working in geropsychology (APA Working Group on the Older Adult, 1998; APA, Division 20 and Division 12, Section II 1998). These organizations and increased training opportunities in professional geropsychology have helped to encourage interested providers to consider specializing in working with older clients. Providers have reported a high level of satisfaction with training in geropsychology and in their clinic work with older adults (Karel, Molinari, Gallagher-Thompson, & Hillman, 1999). These trends indicate that attitudes and interests of providers should be less of a barrier to services than in the past. However, recent research surveying mental health providers found that a shortage still exists in the availability of mental health providers specifically trained in geropsychology (Qualls,

Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). Continued efforts to provide continuing education to current providers on treating older adults as well as increased training opportunities in geropsychology will be necessary to meet the demands of the growing older population. In addition, improved training of medical professionals who still fail to recognize mental disorders and to refer older adults for treatment will be needed to increase the utilization of mental health services by older adults (Arean et al., 2002).

Several articles have suggested that the failure of older adults to utilize health care services may be explained by external barriers such as limited financial resources and a lack of transportation to obtaining appropriate services (Fortney, Booth, Blow, & Bunn, 1995; Rosenheck & Stolar, 1998). Rokke and Klenow (1998) examined these factors in a study on the prevalence of depressive symptoms in rural elderly adults in North Dakota. They conducted a telephone survey of over 1500 adults ranging in age from 59 to 99 in which they inquired about depressive symptoms, the likelihood of individuals to seek treatment for these symptoms and perceived barriers to receiving this treatment. Despite the fact that many participants were limited in income and lived a considerable distance from available services, most reported that affordability of and transportation to services were not a barrier to their seeking services, even for those who reported depressive symptoms. Rokke and Klenow concluded that while these factors may play a small role in service utilization, they are not the primary reason for older adults, even those living in rural areas, to avoid mental health treatment.

Costs, transportation, provider attitudes and the Medicare system may discourage older adults from seeking mental health services. But it seems that none of these factors

capture the essential elements unique to the service experience of older adults. Similar external barriers exist in providing services to clients of all age groups. Concerns regarding the cost of treatment and frustration with health care delivery have been reported by a large portion of the general public (Farberman, 1997). In addition, provider attitudes appear to be improving with the increase in interest and specialized training in geropsychology. Thus, external barriers may be important, but are not sufficient in explaining the pattern of utilization observed in older patients. It appears that older patients' knowledge, attitudes, and beliefs regarding psychotherapy are playing a large role in service utilization. These variables have also received attention in the literature on the general public's utilization of services (Farberman, 1997; Murstein & Fontaine, 1993) although there appears to be a lack of clear consensus on which factors relate most to utilization. For older adults, less emphasis on these factors appears in recent literature and little has been done to address or change these attitudes. It is essential that these factors are explored when external barriers have not been shown to fully account for the underutilization of services by older adults. The existing previous literature is reviewed below on older adults' attitudes and beliefs that may affect service utilization.

## Internal Factors

In considering why older adults fail to utilize mental health services, it may be important to understand first the experience of those who do choose to utilize services. Only one study has specifically asked older adult service users to describe their decision to seek treatment. Speer, Williams, West and Dupree (1991) interviewed 23 clients (aged 55 and over) at a specialty mental health clinic for older adults in regards to their treatment experience. Clients identified friends, family, medical providers, and local

advertising in newspapers as their referral sources. Over one half of the sample reported not ever considering that a stigma might be associated with treatment and an additional 25% of the sample said that they had initially been concerned about the stigma but felt that getting help for their problems was more important than these concerns. In addition, clients reported that they were generally satisfied with their treatment experience and stated that they would refer a friend for treatment. Thus, it appears that experience with mental health providers in this case was a positive experience and that the stigma associated with treatment was not a significant deterrent from seeking services.

These findings are consistent with more recent findings indicating that the stigma of mental health treatment is not a major barrier to treatment for older adults (Rokke & Klenow, 1998; Rokke & Scogin, 1995). This might seem surprising given the fact that many writers have referred to the stigma of mental illness as playing a major role in inhibiting older adults from utilizing services (Arean and Gallagher-Thompson, 1996; Lazarus et al., 1991; Yang & Jackson, 1998). Two caveats appear important to keep in mind. The first is that the stigma may be greater for the current cohort of older adults than for those in younger cohorts (Currin et al., 1998). If this is the case, the results of each study would vary, depending on if the sample was made up of those in the Post-War, WWII or Depression cohort. Thus, results on the importance of stigma may vary based on the age and cohort of the sample in each study. In addition, cultural factors are likely to influence the stigma associated with mental health services and thus, the cultural make-up of the sample is important to consider. Finally, an important distinction in resolving these contradictory findings is the difference between a concern that a stigma exists and in determining whether or not stigma actually has an impact on treatment

seeking. Individuals may be able to overcome the fear of what others may think of them if they believe treatment can work (Speer et al., 1991). A failure to believe in therapy and providers may be more detrimental to seeking services than fears regarding stigma.

Waxman, Carner and Klein (1984) conducted one of the first and only studies in which older adults' attitudes toward mental health were closely examined and then related to decisions to seek treatment. An additional strength of this study is the diversity of the sample, which was 45% African American and included members from both middle and lower class backgrounds. This article continues to be important today, given that its findings may be more applicable to a large range of individuals due to its diverse sample. In addition, it is consistently cited in the literature in explanations of how older adults' attitudes impact utilization (Currin et al., 1998; Jenkins & Laditka, 1998; Phillips & Murrell, 1994; Speer et al., 1991).

Waxman and colleagues (1984) gave participants descriptions of depression, organic brain syndrome and cardiovascular disease and asked if they would report the symptoms to a friend, family member or health professional. In addition, Waxman and colleagues asked which professional participants would visit for help and which professional they felt would be most effective in treatment. Only approximately one half of the sample was willing to report the symptoms of depression or organic brain syndrome to a professional, while 72% were willing to report the symptoms of cardiovascular disease. Most participants reported being likely to seek help with any of the three conditions from a general physician and felt that a general physician would be the most effective in treating all three conditions. In addition, participants' attitudes toward mental health treatment predicted the likelihood of seeking professional help for

depression and organic brain syndrome. Waxman and colleagues concluded that older adults were unlikely to seek mental health services in the future, even if serious symptoms were occurring, but that participants' attitudes toward the mental health system was important in predicting their behavior. Therefore, by changing attitudes to be more positive and working more closely with physicians, Waxman and colleagues felt it was possible to improve this pattern of utilization.

Since this study, there have been some follow-up studies suggesting similar conclusions regarding older adults' attitudes. In the 1990s, several studies reported findings suggesting that older adults have negative attitudes towards psychological services as well as a lack of knowledge about which services are helpful or effective (Lasocki & Thelen, 1987; Lundervold & Young, 1992). It appeared that these attitudes explained findings that most older adults prefer to seek treatment for psychological symptoms from their medical doctor. Phillips and Murrell (1994) found in a two-year prospective study that out of 120 older adults who sought help for psychological symptoms, 111 went to their primary medical care doctor. This trend was consistent across race, SES, and the availability of service in their area. It appears that the attitudes of older adults have an impact on their utilization of mental health treatment. They feel more comfortable seeking help for psychological symptoms from medical providers and are often reluctant to report these symptoms at all.

More recent research has found that older adults may have more positive attitudes towards psychological treatment than previously reported. Many studies have found that older adults, in general, find psychological services to be an acceptable treatment alternative (Landreville et al., 2000; Rokke and Scogin, 1995). What these studies fail to

address is if older adults would consider these services acceptable for themselves. In other words, the difference between these studies and those reporting more negative attitudes appears to be if older adults are reporting their views of psychological treatment in general, or whether they are responding regarding their openness to receiving psychological treatment themselves. In addition, a distinction may exist in whether older adults are open to receiving this treatment from a mental health, rather than their medical health provider.

In a recent study which addressed this distinction, Arean, Alvidrez, Barrera, Robinson and Hicks (2002) found that 79% of primary care patients, aged 55 and older, indicated that they would be open to receiving psychological services. However, 61% of these individuals reported that they would prefer to discuss psychosocial problems with their primary care doctor. Similar results were found for those individuals who were found to be depressed in the sample. These results are positive, in the sense that they represent an openness and willingness to utilize psychological services or discuss emotional problems which may not have been predicted given older adults' use of mental health services. Along with studies reporting a preference for psychotherapy over anti-depressant medication (Landreville et al., 2001; Rokke and Scogin, 1995), these findings suggest that older adults attitudes towards psychological services may be improving. However, the fact that these findings have not been accompanied by significant changes in service utilization and that older adults continue to report a preference to receive help for psychological problems from their primary care provider, suggest that an improvement in the general attitudes of older adults may not be significantly changing their behaviors when it comes to addressing psychological concerns.

While the studies reviewed here have suggested that important external and internal factors contribute to older adults avoidance of mental health treatment, they fail to address fears older adults may have about treatment itself. These fears may help to explain why improved attitudes towards psychological services may not be sufficient in increasing the utilization of mental health services by older adults. Studies examining general attitudes towards psychotherapy fail to reveal specific concerns that older adults may have about what treatment with a mental health provider entails. The fact that older adults often report psychological symptoms to their primary care doctor suggests that the stigma of their symptoms or their lack of psychological knowledge does not sufficiently account for their underutilization of treatment. If this were the case, we might expect them to avoid reporting the symptoms to any provider. Instead, it may be that older adults are fearful of psychological treatment, the stigma of seeking help for psychological symptoms from a mental health provider and the processes involved in psychotherapy.

The first concern in seeking treatment for older adults may be their fears that an underlying dementia will be discovered in the course of psychological treatment. Little work has been done in examining the fears of Alzheimer's disease or dementia that older adults may experience. However, given the media and providers' attention on these disorders (Gatz & Pearson, 1988), it is quite likely that older adults fear dementia. For older adults who are fearful of dementia, psychological treatment may be especially threatening given the nature of therapy. Older adults may worry that in talking about their difficulties, they will reveal memory loss or a decrease in functioning. In presenting symptoms instead to a medical doctor, the older adult may be apt to describe a physical description of symptoms and may believe that resulting medical treatment will not

intrude in their lives. In reviewing the literature, only one study has measured fear of Alzheimer's disease and beliefs about memory control in aging (Lachman, Bandura, Weaver, & Elliott, 1995). Beliefs regarding memory control and fears of Alzheimer's disease were explored here in respect to service utilization, given that these fears could lead to treatment avoidance.

In addition to specific fears regarding dementia or memory loss, treatment fearfulness may be an important area to examine among older adults. Kushner and Sher (1989) developed the construct and original measure of treatment fearfulness (Thoughts About Therapy Scale). Treatment fearfulness is defined as "a subjective state of apprehension arising from aversive expectations surrounding the seeking and consuming of mental health services" (Kushner & Sher, 1989, 251). Four dimensions make up treatment fearfulness. The first is image concern, the fear of being judged negatively by oneself and by others for seeking therapy. The second is therapist responsiveness, which includes fears of who the therapist will be and if the therapist will be competent to treat the individual's problems. The third dimension is coercion concern, which includes fears that individuals will be forced to think, do, or say things against their will during therapy. The fourth dimension, introduced by Deane and Chamberlain (1994), is stigma concern, which includes fears concerning the social image and ramifications of attending therapy with a mental health provider.

The treatment fearfulness construct expands on the notion that attitudes have an impact on utilization in that it focuses on the specific experience of treatment rather than just on attitudes towards psychology treatments in general. Treatment fearfulness addresses the experiences that one may expect to have during a therapy session rather

than simply testing whether one believes in the value of attending sessions at all. Kushner and Sher (1991) have identified treatment fearfulness as arising from multiple sources including past negative experiences with the mental health system, treatment stereotypes, and specific mental health problems such as anxiety disorders. In addition, there is evidence to suggest that treatment fearfulness is culturally influenced. It is thought to be a dynamic concept which changes over time and may impact all stages of the help-seeking process and progress in therapy (Kushner & Sher, 1991).

In research examining treatment fearfulness, Miller's (1944) influential approach-avoidance theory has been applied to service utilization by Kushner and Sher (1989; 1991). Using this framework, the decision to seek treatment is thought to be determined by competing internal motivational and inhibitory influences of varying strengths (Kushner & Sher, 1989; Miller, 1944). Treatment fearfulness is one of the inhibitory influences in this model that may lead to an individual's decision to avoid seeking help. Kushner and Sher found in a college sample that participants about to enter treatment reported less treatment fearfulness than those not considering services. In addition to treatment fearfulness relating directly to utilization, Kushner and Sher have shown that increased distress related positively to treatment fearfulness and to the likelihood of seeking services. This finding is explained using the approach-avoidance theory. Avoidance influences are likely to be stronger as the individual considers the need for therapy to be stronger. Thus, as the need increases for therapy, an individual is likely to experience an increase in both avoidance and motivation. Individuals in distress, such as those reporting high levels of depressive symptoms, are likely to both highly fear, and yet desire, treatment.

In addition to contributing to the basic understanding of utilization, Kushner and Sher (1991) speculate that treatment fearfulness may be useful in understanding differential rates of utilization for specific groups. Specific groups may have heightened fears in any of the four dimensions based on their social and cultural systems and expectations of treatment. Kushner and Sher suggest that treatment fearfulness should be examined in minority populations, with respect to gender, and in the older adult population.

Recent studies have introduced the concept of self-concealment as a possible fifth dimension of treatment fearfulness. Self-concealment is the behavior one engages in to avoid revealing to others information that may be perceived as negative or distressing (Larson & Chastain, 1990). It can be thought of as the fear that treatment will entail revealing information that causes distress both to the individual and to those associated with the individual. Some researchers have suggested that those high in self-concealment are less likely to seek counseling (Cepeda-Benito & Short, 1998), while others have suggested high self-concealment leads to an increased likelihood to seek counseling (Kelly & Achter, 1995). These contradictory results have been explained in terms of level of distress being an important moderator, as discussed above. A tendency to engage in self-concealment may lead to increased distress and increase the likelihood of seeking services. However, if concealment is experienced with low levels of distress, it may increase avoidance of services (Cramer, 1999). This finding is supported by recent work suggesting that fear of emotions also may predict negative attitudes towards treatment (Komiya, Good, & Sherrod, 2000). The level of distress produced by avoiding emotions or concealing problems influences the likelihood of treatment seeking. It is clear that

much work remains to be done in clarifying the specific role of the self-concealment dimension, especially given the fact that all of these studies were conducted with college-aged samples. Self-concealment could be important for older adults, especially with regard to dementia. Older adults may be concealing symptoms of dementia and depression out of fear and as a way to avoid distress.

## Purpose and Hypotheses

The purpose of this study was to suggest ways in which current explanations of underutilization may be insufficient in providing a clear understanding of the barriers between older clients and psychological services. Ultimately, by gaining a better understanding of these barriers, specific interventions could be developed to increase service utilization by the older adult population. Specifically, the goal here was to examine how many of the barriers described in past research and the new barriers suggested here predicted past utilization of mental health services and future likelihood of seeking these services. Most importantly, this study attempted to add to the current research on utilization by examining several barriers at one time and providing descriptive information on older adults' views of mental health services. Predictions were suggested based on past research, but much of the study's focus was exploratory. Due to the limited research in which several barriers are considered and the need for information in this area, the study's aim was to provide as much information as possible on the relevant barriers to older adults' utilization of services as well as test relevant relationships between these barriers.

The first factors examined were demographic factors, including gender, SES, and age. Women and those in higher SES groups have been reported to seek services at a

higher rate than men and those in lower SES groups (Leaf et al., 1987). In addition, cohort differences have been reported that indicate the attitudes of those in younger age groups (middle-aged) should be more positive than those in older age groups (those over 65) (Currin et al., 1998). The older adult groups were also hypothesized to report more treatment fears based on past research indicating that they possess less knowledge about what therapy may actually entail (Lundervold & Young, 1992). Thus, the following three hypotheses were proposed regarding the demographic factors:

1) Women will report higher rates of past service utilization and a greater likelihood to seek mental health services in the future than men.

2) Those in higher SES groups will report higher rates of past service utilization and a greater likelihood to seek mental health services in the future than those in lower SES groups.

3) Members of the Baby Boom Cohorts (I and II) will report more positive attitudes regarding mental health services and less treatment fearfulness than older adult who are a part of the Post-War, Depression and WWII cohorts.

The next factors examined were the external barriers that may limit older adults' utilization of services. Specifically, cost, transportation, and health insurance were examined. Despite the fact that research has shown transportation and cost do not significantly predict utilization, they continue to be discussed in the literature as significant barriers. Therefore, it is necessary to gather further evidence on their import to utilization. It was hypothesized that transportation and cost would not be found to be significant single predictors of utilization, given the results presented by Rokke and

Klenow (1998). Medicare has been cited in the literature as being crucial to utilization, but has not been tested as a factor in predicting the utilization of services. Medicare was hypothesized to be a negative predictor of past service utilization and future likelihood of seeking services in the future. It was predicted that those who have supplemental insurance in addition to Medicare would be most likely to have utilized services in the past and to indicate a higher likelihood of seeking services in the future. In addition, it appears likely that many older adults lack knowledge of how their insurance may reimburse psychological services, especially given that the system can be confusing (Koenig et al., 1994). Therefore, it was also predicted that those who know their insurance company's policy on mental health coverage would be more likely to report utilizing past services and utilizing services in the future. Thus, the following hypotheses were proposed for the external factors (Hypotheses 4-7):

4) Transportation and cost will not be reported as significant barriers to utilization. They will not be found to significantly predict past or future service utilization.

5) Medicare insurance will be a significant negative predictor of service utilization of past services and future likelihood of seeking services.

6) Those with supplemental insurance and Medicare will report higher rates of past utilization of services and a higher likelihood of seeking mental health services in the future than those with Medicare alone.

7) Individuals who report knowledge of their insurance company's policy on mental health coverage will report higher rates of past utilization and a higher

likelihood of seeking mental health services in the future than those who do not know the policy.

Finally, the internal barriers to service utilization were examined. The following factors were considered: treatment fearfulness, self-concealment, fears of aging and memory control, attitudes towards psychotherapy and depression. Each of these factors (which are made up of several subscales) was hypothesized to significantly predict service utilization. Attitudes towards psychotherapy and depression have been examined in past literature and found to predict service utilization, while treatment fearfulness, self-concealment, and fears of aging and memory control are new variables. The approach-avoidance framework was used to predict the direction of each of these internal barriers. All aspects of treatment fearfulness, the belief in the inevitable decline of memory, the fear of Alzheimer's, and self-concealment were hypothesized to be avoidance factors. Treatment fearfulness has been found to be negatively related to service utilization in past literature and all of these factors are presumed to increase the fear of a participant in seeking psychotherapy. In addition, by believing that aging is related to inevitable decline, an individual is unlikely to believe that psychotherapy can be useful in promoting positive change. Therefore it was hypothesized that these factors would be negatively related to both past and future service utilization. In contrast attitudes towards psychotherapy, beliefs in one's present memory ability, beliefs in the potential to improve memory, beliefs in the utility of effort to control memory, beliefs that one maintains independence with aging and current depressive symptoms were hypothesized to be motivating factors to seeking psychotherapy. Attitudes towards psychotherapy was found to positively predict service utilization in past research. It was

assumed that individuals who do not fear aging would not be concerned that psychotherapy could reveal problems with memory or aging decline. Depression is assumed to increase the level of distress for an individual which should encourage them to consider psychotherapy. Therefore, it was hypothesized that these factors would be positively related to past service utilization and would increase the likelihood of seeking therapy.

Lastly, it was hypothesized that while depression and distress should increase the likelihood of an individual seeking services, the avoidance factors would be stronger in depressed individuals than non-depressed individuals due to their increased need for services. Therefore, it was hypothesized that they would report higher levels of treatment fearfulness, more negative attitudes towards psychotherapy, higher levels of fears regarding aging and dementia and stronger beliefs that memory loss is inevitable. The following hypotheses (Hypotheses 8-13) were proposed for the internal factors:

8) Treatment fearfulness will be found to predict past service utilization and future likelihood of seeking mental health services. All subscales of the treatment fearfulness measure (therapist responsiveness concerns, image concerns, coercion concerns, and stigma concerns) are hypothesized to be negatively related to past and future mental health service utilization.

9) Beliefs regarding memory controllability will be found to predict past service utilization and likelihood of future service utilization. The subscale involving the belief that memory cannot be controlled will be negatively related to service utilization (inevitable decline). The subscales involving beliefs that memory can be controlled with aging (present memory ability, potential improvement, effort

utility, and independence) were hypothesized to be positively related to service utilization.

10) Concerns regarding aging will be found to predict past service utilization and likelihood of future utilization. The belief that independence can be maintained with age will be positively associated with service utilization and the belief that it is highly likely one will develop Alzheimer's disease will be negatively associated with service utilization.

11) Self-concealment will be found to negatively predict past service utilization and likelihood of future service utilization.

12) Attitudes towards psychotherapy will be found to positively predict past service utilization and likelihood of future service utilization.

13) Significant depressive symptoms will be found to positively predict past service utilization and likelihood of future service utilization.

14) Higher scores will be found on treatment fearfulness, fears regarding aging and dementia, beliefs regarding inevitable memory loss, and negative attitudes towards psychotherapy for those individuals who report clinically significant depressive symptoms.

In addition to these specific hypotheses, many exploratory analyses were performed testing regression models that incorporated the demographic, external and internal factors presented here. Despite the fact that important barriers to service utilization have been presented in the literature, there has not been research in which barriers are considered together. Therefore, these analyses were guided by the assumption that internal factors are more important for predicting utilization than the external factors

since the external factors have been less supported in the research. However, with such little knowledge on how these barriers may relate to each other or contribute to utilization as a group, it was important to use the data gathered here to explore many possible relationships to learn more about utilization in older and middle-aged adults.

# CHAPTER II

# METHODS

## Participants

A sample of community adults (214 females and 129 males), recruited by college students, participated in the present investigation. The sample ranged in age from 40 to 91 years of age (M = 58.01, SD = 12.27). Five cohorts were represented in the sample, 14.9 % of the sample was from the depression cohort (born between 1912 and 1921) or World War II cohort (born 1922-1927), 30.6 % of the sample was from the Post-War Cohort (born 1928 to 1945), 37.3% of the sample was from the first Baby Boomer cohort (born 1946 to 1955) and 17.6% of the sample was from the second Baby Boomer cohort (born 1956 to 1965).

The demographics of the sample are shown in Table 1. The demographics are shown separately for the Baby Boomers and the older adult cohorts. As can be seen in Table 1, approximately one-third of the sample was the age of sixty-five or over (30.9%) and one third was retired (31.9%). The sample contained more women (62.4%) than men (37.6%). The majority of the sample was married (67.3%), Caucasian (95%), and owned a home (82.1%). The sample was well-educated, with over one half of the participants (58.4%) completing some college education. However, education levels ranged from 7 to 24 years of education completed (M = 14.29, SD = 2.67). In addition to education, occupational prestige scores were calculated, using the National Opinion Research Center's classifications of prestige (1998). The majority of the sample's occupations were in the middle classes of occupational prestige (M = 49.10, SD =14.10). The Baby

Boomers' (M = 49.10, SD =14.10) level of occupational prestige was slightly higher than the older adult group (M = 46.65, SD =14.06).

The majority of the sample described themselves as either very (26.5%) or somewhat religious (56.5%). The majority of the sample (91%) reported one of three religious affiliations. Half of the sample reported Catholicism (57.3%), one-fourth reported affiliations with various Protestant sects (25.8%), and approximately one-tenth reported Judaism (11.5%). Almost two-thirds of the sample (63.7%) described their health as "excellent" or "fine" and reported no medical conditions. Only a small percentage (7.4%) reported serious medical conditions (such as cancer or a major heart conditions), while the rest reported more minor or moderate health concerns (such as arthritis or back problems) (17.5%).

## Materials

The questionnaire packet was made up of nine sections (See Appendix for copy of questionnaire packet) and was printed in 20 point Times New Roman font to ensure it was readable to all subjects. In the first section, participants completed a demographic questionnaire concerning their age, race, sex, occupation, years of education, religion, religious attendance, religiosity and marital status. In addition, the demographic questionnaire included a question asking for a description of any current mental or physical ailments. This questionnaire was created in past research studies and used with older adult subjects (Whitbourne, Sneed, & Skultety, in press). However, the questions regarding religion were added as a part of this study.

In the second section, participants completed a history of their utilization of services. This questionnaire was used in the study conducted by Waxman and collegues

(1984) and obtains information regarding if the participant has ever sought the services of a general physician, psychologist, psychiatrist, social worker, internist and dentist. In addition, the participant was asked to indicate how many times they saw each of these providers in the past year.

In the third section, participants completed a questionnaire regarding health insurance, affordability and transportation. The questions regarding health insurance were created for this study. They entailed yes/no questions regarding if the participant is enrolled in Medicare, Medicaid or other health insurance. In addition, participants were asked to indicate if they know the reimbursement policy for psychological services from their insurance plan and if they are satisfied with this policy. The questions regarding transportation and cost were obtained from the study conducted by Rokke and Klenow (1998) in which subjects were asked questions over the phone regarding barriers to health services. Two questions asked directly if cost or transportation prevents the participant from seeking mental health services. In addition, a question was included asking how the participant would get to a provider for services. The choices included: drive myself, have a family member or spouse drive me, walk, take public transportation, take a taxicab and other.

In the fourth section, participants were asked to complete the Thoughts About Psychotherapy Scale (TAPS; Kushner & Sher, 1989). Subjects were instructed to imagine they had decided to seek the help of a therapist or counselor for a personal problem and then asked a series of questions regarding the concerns they would have. This scale measures treatment fearfulness, by having subjects respond to each item on a 1 (not concerned) to 5 (extremely concerned) Likert scale. The scale originated from the 15 item

Thoughts About Counseling Scale (TACS; Pipes, Schwarz, & Crouch, 1985) and then was expanded to 19 items by Kushner and Sher in 1989. This version of the TAPS measured three dimensions of treatment fearfulness: therapist responsiveness, image concerns and coercion concerns. In addition, Kushner and Sher expanded the definitions of mental health professionals that were used in the TACS to include psychologist, social worker and psychiatrist. Deane and Chamberlin revised the TAPS again in 1994 by expanding the scale to 30 items and adding the dimension of social stigma. The social stigma dimension measures fears concerning the social image and ramifications of attending therapy. An example from this dimension is, "Whether attending therapy will create a psychiatric label that might stay with me." The image concern dimension measures the fear of being negatively judged by themselves and others by seeking therapy. An example from this dimension is, "Whether the therapist will think I'm a bad person if I talk about everything that I have been thinking and feeling." The therapist responsiveness dimension measures fears of the therapist's professionalism and competence. An example from this dimension is "Whether the therapist will understand my problem." The coercion concern dimension measures the fear of unwanted changes that may occur within the therapy process and as outcomes of treatment. An example from this dimension is, "Whether I will be pressured into talking about things that I don't want to." The scale's reliability, using Cronbach's alpha, has been reported to range from .87 to .94 for the total scale (Deane & Chamberlain, 1994; Kushner & Sher, 1989). Deane and Chamberlin (1994) reported alpha coefficients of .89 for the therapist responsiveness dimension, .82 for the image concerns dimension, .80 for the coercion concerns dimension and .93 for the stigma concerns dimension. In the present

investigation, Cronbach's alpha was .95 for the total scale, .91 for the therapist responsiveness dimension, .89 for the image concerns dimension, .86 for the coercion concerns dimension and .93 for the stigma concerns dimension. The scale has been found to correlate with measures of state anxiety suggesting concurrent validity and negatively correlated with questionnaires measuring treatment expectation suggesting construct validity (Deane & Chamberlain, 1994). Following the 30 items on treatment fears, the subject was asked how likely it was that they would actually seek therapy if they had a personal problem. Subjects responded on a one to nine Likert Scale.

In the fifth section of the questionnaire, subjects were asked to complete the Memory Controllability Inventory and the Aging Concerns Scale (MCI and ACS; Lachman et al., 1995). The MCI measures different conceptions of memory control and ability using four sub-scales. Specifically it examines participants' beliefs of their present ability (Present Ability Subscale) to remember, their level of confidence that strategies can be found to improve memory (Potential Improvement Subscale), their beliefs that memory can be controlled with effort (Effort Utility Subscale), and their beliefs regarding inevitable memory decline with aging (The Inevitable Decrement Subscale). It consists of 12 items which subjects respond to on a 1 (strongly disagree) to 7 (strongly agree) Likert scale. Coefficient alpha has been found to range from .58 to .77 for the four subscales (Lachman et al., 1995). In the present investigation, Cronbach's alpha was .67 for the present ability subscale, .59 for the potential improvement subscale, .74 for the effort utility subscale and .56 for the inevitable decrement subscale. In past studies, test-retest reliability for the four subscales ranged from .50 to .65 over a 9 day period and .46 to .57 over a three month period. Lachman and colleagues (1995) have supported the scale's

validity by finding predicted correlations between the subscales. The Present Ability, Potential Improvement and Effort Utility Subscales have been found to be significantly correlated and a negative correlation has been found between the Inevitable Decline and Present Ability subscales, especially for older groups (Lachman et al., 1995). In the present investigation, the present ability, potential improvement, and effort utility subscales were significantly positively correlated and a negative correlation was found between the inevitable decrement and present ability subscale.

The seven item ACS measures concerns about aging for older adults. It consists of 8 items which are interspersed throughout the MCI. The items measure two concerns. The first is managing memory problems and the second is the fear of developing Alzheimer's disease. Participants respond using the same Likert scale described above for the MCI. The coefficient alpha has been reported to range from .49 to .68 for the items regarding Independence and .65 to .73 for the items concerning fears of Alzheimer's (Lachman et al., 1995). In the present investigation, Cronbach's alpha was .61 for the independence subscale and .61 for the Alzheimer's likelihood scale.

In the sixth section of the questionnaire, participants were asked to complete the Geriatric Depression Scale- Short Form (GDS-15; Sheikh & Yesavage, 1986). This scale consists of 15 yes or no items that measure current depressive symptoms among older adults. Scores of seven or higher have been found to be consistent with depression diagnoses, while a score of 4 to 7 is considered to be possibly indicative of a depression diagnosis. The GDS-15 was derived from the original 30 item Geriatric Depression Scale (Yesavage & Brink, 1983). It has been found to be equally valid in differentiating depressed and non-depressed subjects as compared with the 30 item version. The scale

has been found to be reliable with a Cronbach's alpha of .87 (Cheng & Bocy, 2000). In the present investigation, the Cronbach's alpha was .74.

In the seventh section of the questionnaire, participants were asked to complete the Self Concealment Scale (SCS; Larson & Chastain, 1990). The SCS was developed to measure the "predisposition to actively conceal from others personal information that one perceives as distressing or negative" (Larson & Chastain, 1990, pg. 440). It consists of 10 items which participants respond to on a 5 point Likert scale ranging from strongly disagree (1) to strongly agree (5). Responses of the items are summed, with higher scores indicating greater self-concealment. The SCS is reported to have high test-retest reliability (.81) and a Cronbach's alpha of .83 (Larson & Chastain, 1990). Factor analyses have found the SCS to be an essentially unidimensional instrument and conceptually different than self-disclosure alone (Larson & Chastain, 1990). In the present investigation, Cronbach's alpha was .89.

In section eight, participants were asked to complete a measure of their perception of help-seeking behavior developed by Waxman and colleagues (1984). In these questions, participants are given descriptions of depression, dementia, and cardiovascular disease and asked a set of common questions for each description. After a description of the disorder, in which only symptoms, not disorders by name, are mentioned, participants are asked who they would tell about the symptoms (no one, family member, or health professional), whom they would visit for professional help for these symptoms (general physician, psychologist, psychiatrist, or internist), and whom they thought would be most effective in helping them (general physician, psychologist, psychiatrist, or internist). This measure has been found to be correlated with attitudes towards mental health.

In the ninth section of the questionnaire packet, participants completed the short form of the Fischer-Turner Attitudes Toward Seeking Professional Help Scale (TAPS; Fischer & Farina, 1995; Fischer & Turner, 1970). The original scale was developed in 1970 and consisted of 29 items measuring attitudes towards traditional counseling services. Participants are asked to respond to each item on a 4 point Likert scale ranging from agree (0) to disagree (3). It was found to have high internal consistency (alpha ranging from .83 to .86), low correlation with scales of social desirability and discriminate between participants who have sought assistance and those who have not (Fischer & Turner, 1970). Responses are summed with higher scores indicating more positive attitudes towards seeking professional help. More recently, a shorter form of the scale has been developed which consists of ten items from the original scale. These ten items were chosen because of they were found to have factor loadings above .50. The short form of the scale has been reported to also have high reliability, with a Cronbach's alpha of .84. In the present investigation, Cronbach's alpha was .85. In addition the test-retest correlation was found to be .80 over a one-month interval (Fischer & Farina, 1995). Fischer and Farina (1995) conclude that the short form has "all the psychometric properties of the original scale" (pg. 372) and recommend its use over the original scale.

Following the nine sections of the questionnaire, the participants had the opportunity to indicate whether they found any sections or questions to be confusing and then to explain how they answered these portions of the questionnaire. This was done in an attempt to identify any area which may have caused confusion for a large percentage of the sample. In addition, there was an open-ended question asking the participant about their views on mental health service. This question allowed for participants to share their

views on psychotherapy and utilization barriers and added narrative information to the results obtained using the questionnaires.

The use of mental health services was examined by four dependent variables: past utilization and three measures of future utilization. For past utilization, participants were considered to have used services if they indicated in section two that they had ever sought the services of a psychologist, psychiatrist or social worker. For future utilization, two variables were examined. The first, future likelihood of utilization, was measured by the 1 (extremely likely) to 9 (extremely likely) Likert scale ratings for the single item, "If you did have a personal problem how likely is it that you would seek help from a professional psychologist or counselor?" This question followed the TAPS questionnaire. The second measure of future likelihood was obtained from the situational questionnaire found in section eight of the questionnaire packet. Participants who indicated that they would visit a psychologist, psychiatrist, or social worker first for depression symptoms were considered to be likely to utilize future services; by contrast, those who indicated they would visit a general physician or internist first were considered to not be likely to utilize future services. In addition, participants who indicated that they thought a psychologist, psychiatrist, or social worker would be most effective in helping them with symptoms of depression were considered to be likely to utilize future services, while those who thought a general physician or internist would be most effective in helping them with symptoms of depression were considered to be less likely to utilize future services.

## Procedure

Three weeks prior to distributing the questionnaires, students were asked in an advanced psychology course to sign up to participate in the study. They were instructed

to obtain volunteers, aged 40 and older, to complete the questionnaires. Students were instructed that they could not recruit more than one family member, but could recruit as many as six non-related subjects to participate. In exchange for their own participation, the students received extra points of extra credit (20 out of 360 total points) for the course. Following the explanation of the study and what would be required of them, students completed a form indicating who they would be able to recruit as volunteers. Students indicated the gender and age of both a relative and non-relatives that they felt they could recruit. These forms were sorted into groups based on the relative the student indicated that they could recruit. In an attempt to obtain significant representation from the older and middle aged groups as well as both genders, students were assigned a relative to recruit. They were told they would receive 5 points for recruiting the assigned relative and 2 points for each additional non-related participant. Finally, students were told that they would be asked to supply the names, gender, and ages of the participants they recruited, in order to insure that they had followed the instructions and assignment. This information was kept separate from the data collected, in order to maintain subjects' confidentiality.

The questionnaires were distributed during the class from March 3-17th. Students were asked to take a limited number of questionnaires and then obtain more when they had completed the initial packets. In addition, questionnaires were made available to be picked up from outside the professor's office. Each copy of the questionnaire included a consent form and directions asking the participants to respond to all possible items. In addition, the last page of the questionnaire included a de-briefing form for the participants. The questionnaires were accompanied by instructions for the student, a list

indicating who the student has been assigned to recruit and return envelopes which participants will be asked to seal. The participants were asked to place a sticker over the flap of the envelope in order to insure the college student did not open it before returning the questionnaire. This served as a precaution to protect the confidentiality of the volunteers recruited by the students. Following the students' Spring and holiday break, the students were given several opportunities to turn in their questionnaires as well as a separate sheet of paper indicating the names, ages, and contact information of the subjects' they had recruited. The forms and questionnaires were collected during class and outside the professor's office and students were awarded their extra credit.

Table 1

Demographic Characteristics of Sample (N = 343)

| | Baby Boomers (187) | % | Older Cohorts (156) | % |
|---|---|---|---|---|
| Sex | | | | |
| Male | 65 | 34.8 | 64 | 41.0 |
| Female | 122 | 65.2 | 92 | 59.0 |
| Retired | | | | |
| Yes | 8 | 4.3 | 101 | 64.7 |
| No | 178 | 95.2 | 54 | 34.7 |
| Marital Status | | | | |
| Single | 20 | 10.7 | 13 | 8.3 |
| Married | 140 | 74.9 | 91 | 58.3 |
| Cohabitating | 4 | 2.1 | 0 | 0.0 |
| Separated/Divorced | 19 | 10.1 | 14 | 9.0 |
| Widowed | 4 | 2.1 | 38 | 24.4 |
| Level of Education (Years) | | | | |
| 11 or Less | 2 | 1.1 | 14 | 9.0 |
| High School Grad (12) | 52 | 28.0 | 74 | 47.4 |
| Some college (13-15) | 29 | 15.5 | 18 | 11.6 |
| College Grad (16) | 57 | 30.5 | 22 | 14.1 |
| Graduate Work (17+) | 46 | 24.4 | 27 | 17.3 |
| Ethnicity | | | | |
| Caucasian | 173 | 92.5 | 150 | 96.2 |
| African-American | 8 | 4.3 | 2 | 1.3 |
| Other | 4 | 2.2 | 3 | 1.9 |
| Living Situation | | | | |
| Rent | 25 | 13.3 | 13 | 8.3 |
| Home of Children | 0 | 0.0 | 7 | 4.5 |
| Retirement Community | 0 | 0.0 | 9 | 5.8 |
| Other | 2 | 1.1 | 5 | 3.2 |
| Religion | | | | |
| Catholic | 95 | 50.8 | 78 | 50.0 |
| Protestant | 43 | 23.0 | 40 | 25.6 |
| Jewish | 21 | 11.2 | 16 | 10.3 |
| Other | 7 | 3.7 | 3 | 1.9 |
| None | 7 | 3.7 | 12 | 7.7 |
| Religiosity | | | | |
| Very | 43 | 23.0 | 47 | 30.1 |
| Somewhat | 110 | 58.8 | 82 | 52.6 |
| Not at all | 31 | 16.6 | 26 | 16.7 |
| Health | | | | |
| Good or Excellent | 114 | 61.0 | 70 | 44.9 |
| Fair/Minor Condition | 48 | 25.7 | 42 | 26.9 |
| Moderate Condition | 14 | 7.5 | 23 | 14.8 |
| Poor/Major Condition | 7 | 3.7 | 18 | 11.5 |

# CHAPTER III

# RESULTS

## Mental Health Service Utilization Descriptives

Four dependent measures were used to examine mental health service utilization: past utilization of services, future likelihood of service utilization, responses regarding who participants would seek help from first for depressive symptoms and responses regarding who participants felt would be most effective in treating depressive symptoms.

32% of the sample had sought services from a mental health provider in the past. Of those who had utilized mental health services, 32% had sought services from a social worker, 47.3% had sought services from a psychiatrist, and 70% had sought services from a psychologist. These percentages indicate that many individuals had sought services from more than one mental health provider. Of those individuals who had seen a psychologist, 31.3% had seen one in the past year and they reported a range of 1 to 45 visits over the year ($M = 9.48$, $SD = 10.31$). Of those who had sought services from a social worker, 29.6% had seen a social worker in the past year and these participants reported a range of 1 to 28 visits over the year ($M = 8.40$, $SD = 10.27$). Of those who had sought services from a psychiatrist, 35.6% had seen a psychiatrist in the past year and reported a range of 1 to 20 visits over the year ($M = 6.56$, $SD = 6.1$). 16 % of the sample had sought counseling from a minister or priest. Of those who had sought counseling from a minister or priest, 63% had also at some time sought the services of a mental health provider. Of those who had sought services from a minister, 35.5% had seen a minister in the past year and reported a range of 1 to 12 visits in the past year ($M = 2.55$, $SD = 2.96$).

When asked how likely it was that they would seek help from a professional psychologist or counselor for a personal problem, participants' responses ranged from 1 (extremely unlikely) to 9 (extremely likely) with a mean response of 5.12 and standard deviation of 2.63. The future likelihood of seeking treatment was positively predicted by past utilization of mental health services ($\underline{B} = 2.70$, $\underline{p} < .01$). Past utilization of services accounted for 23% of the variance of future likelihood of seeking services.

When asked who they would go to first if they experienced depression symptoms, 33.8% indicated they would seek the services of a mental health provider, 60.3% indicated they would seek the services of a physician or internist, and 5.8% did not respond to the question. Of those who indicated they would seek the help of a mental health provider, 68.1% said they would go to a psychologist, 25% said they would go a psychiatrist, and 6.9% said they would go to a social worker.

Those who indicated they would seek the services of a mental health provider reported a significantly higher rate of past mental health utilization than those who reported they would seek the services of a medical health provider, $\chi^2 (1) = 46.69$, $\underline{p} < .01$. Of those who reported they would seek help first from a mental health provider, 57% had seen a mental health provider in the past, whereas only 19.5% of those who reported they would seek help from a medical health provider had seen a mental health provider in the past. In addition, participants who indicated they would seek help from a mental health provider first for depression symptoms ($\underline{M} = 6.04$, $\underline{SD} = 2.52$) scored significantly higher on future likelihood of utilization, $\underline{t} (307) = -3.98$, $\underline{p} < .05$, than those who indicated they would seek help from a general physician or internist ($\underline{M} = 4.84$, $\underline{SD} = 2.53$).

When asked who would be most effective in treating symptoms of depression, 74.7% of the participants said they believed a mental health provider would be most effective. Of those who indicated that a mental health provider would be most effective, 60.9 % thought a psychologist would be the most effective, 36.9% thought a psychiatrist would be the most effective and 2.1% thought a social worker would be the most effective.

Those who believed a mental health provider would be most effective reported a significantly higher frequency of past utilization of mental health services than those who felt a medical provider would be most effective in treating these symptoms, $\chi^2$ (1) = 32.99, $p<.001$. 41.7% of those who believed a mental health provider would be most effective reported past utilization of mental health services, whereas only 6.4% of those who believed a medical provider would be most effective reported past utilization of mental health services. In addition, those participants who indicated they thought a mental health provider would be most effective in treating depression symptoms scored significantly higher on future likelihood of utilizing services ($M = 5.72$, $SD = 2.46$) than those who thought a general physician or internist would be most effective ($M = 4.00$, $SD = 2.60$), $t$ (297) = -5.19, $p <.05$.

## Cohort Utilization Differences

The sample was divided into two cohort groups. The first group will be referred to as the older cohort group and was made up of those in the WWII, Depression and Post-War cohorts (N = 156 ). The second group will be referred to as the Baby Boomers and was made up of those in the Baby Boomer I and Baby Boomer II cohort groups (N = 187).

Baby Boomers reported a significantly higher rate of past mental health service utilization than the older cohort group, $\chi^2$ (1) = 8.69, $p < .01$. 39.2% of Baby Boomers reported having utilized mental health services in the past; by contrast, only 24.2% of the older cohort participants reported past mental health service utilization. For those participants who reported utilizing mental health services, Baby Boomers reported a significantly higher frequency of psychological service utilization than the older cohorts, $\chi^2$ (1) = 6.75, $p < .01$. Of those who had utilized mental health services, 78.1% of Baby Boomers had seen a psychologist in the past while 54.1% of those the older cohort group had seen a psychologist. No differences were found between the Baby Boomers and older cohorts in the utilization of psychiatrist or social worker services.

No significant differences were found between the Baby Boomers and older cohort group for future likelihood of seeking services. Regression analyses revealed no significant prediction of future utilization based on age or cohort regardless of whether past utilization was controlled for or not.

Logistic regression analyses, controlling for past utilization, revealed that cohort group (Baby boomers and older cohorts) predicted whether participants would seek help first from a mental health provider, $\underline{B} = .68$, $p < .05$. Odds ratio analyses indicated that the predicted odds of Baby Boomers indicating that they would go to a mental health provider first for depressive symptoms were approximately 2 times the odds for older adults.

Logistic regression analyses, controlling for past utilization, revealed that cohort group predicted participants responding that a mental health provider would be most effective in treating depressive symptoms, $\underline{B} = .59$, $p < .05$. The predicted odds of Baby

Boomers indicating that they would go to a mental health provider first for depressive symptoms was approximately 2 times the odds for older adults.

Due to the fact that future utilization of services was significantly predicted by past utilization, past utilization was controlled for by being included in all analyses of future utilization. This allowed for the examination of the effects of the various independent variables beyond what was predicted by past utilization of mental health services alone.

Significant differences were found between the cohort groups for both past and future mental health services. Thus, all analyses and hypothesis tests were performed separately for the Baby Boomers and older cohort groups. Tables 2 and 3 show which independent variables were significant predictors of the four dependent measures of utilization for each cohort group when tested individually and for the significant variables which were a part of a scale when tested with all other subscales for the measure.

Demographic Variables

To examine the demographic variables, regressions were conducted in which each demographic variable was tested individually as a significant predictor of each of the four measures of utilization. Logistic regression was used for the dependent measures of past utilization and the situational measures. Simultaneous linear regression was used for the dependent measures of future likelihood of utilization. Past utilization was controlled for in all analyses of future utilization. In addition to the hypothesized variables examined, three exploratory demographic variables were tested as possible predictors of utilization. Religiosity was examined to determine whether those participants who indicated they were "very religious" would be more or less likely to use psychological services than

those who had indicated "somewhat" or "not at all" when asked how religious they considered themselves. Health status was examined to determine whether those participants who indicated that they had no health concerns and described their health as "excellent or good" would be more or less likely to utilize mental health services than those who listed a health condition or gave a less positive description of their health status. The number of physician visits was examined to see if medical health care utilization was predictive of the utilization of mental health services. Descriptive statistics for the demographic variables can be found in Table 1.

## Individual Variable Analyses

For the Baby Boomers, gender ($\underline{B}$ = -.89, $\underline{p}$<.05), occupational prestige ($\underline{B}$ = .04, $\underline{p}$ <.05), education ($\underline{B}$ = .13, $\underline{p}$ <.05), religiosity ($\underline{B}$ = .73, $\underline{p}$ <.05), and physician visits ($\underline{B}$ = .18, $\underline{p}$ <.05) each individually predicted past utilization. The predicted odds for women having seen a mental health provider were 2 times the odds for men. In addition, the odds ratio for education, occupational prestige and physician visits (the factor by which the predicted odds of past utilization are multiplied for each additional year of education, each additional point on the occupational prestige scale and each physician visit) were greater than 1, indicating these factors also increased the odds of past utilization. The predicted odds of those who were very religious to have seen a mental health provider were approximately 2 times the odds of those who indicated they were somewhat or not at all religious. Good health ($\underline{B}$ = .87, $\underline{p}$ <.05) positively predicted participants' responses indicating whether they would seek help from a mental health provider first for depressive symptoms. The predicted odds of those who reported their health as excellent to indicate they would seek help first from a mental health provider were 2.5 times

greater than the odds of those did not report excellent health. None of the demographic variables were found to predict future likelihood of utilization or participants' responses indicating who would be most effective in treating depressive symptoms.

For the older cohort group, none of the demographic variables were found to predict individually past or future likelihood of utilization. However, occupational prestige ($\underline{B}$ = .04, $\underline{p}$<.05), education ($\underline{B}$ = .17, $\underline{p}$<.05), and religiosity ($\underline{B}$ = -1.50, $\underline{p}$<.01) predicted participants' responses indicating whether they would seek help first from a mental health provider for depressive symptoms. The predicted odds ratios for occupational prestige and education show a modest increase in the odds of positive responses to this question: 1.04 and 1.18, respectively. In addition, education ($\underline{B}$ = .17, $\underline{p}$<.05) and religiosity ($\underline{B}$ = -.82, $\underline{p}$<.01) significantly predicted participants' responses indicating whether they would find a mental health provider most effective for treating depressive symptoms. The predicted odds ratio for education was 1.18, indicating each year of education was associated with a modest increase in the odds of participants reporting that a mental health provider would be most effective. The predicted odds of those who indicated they were somewhat or not at all religious were approximately 5 times the odds of those who indicated they were very religious for indicating they would go to a mental health provider first. In addition, the predicted odds of those who indicated they were somewhat or not at all religious were approximately 2 times the odds of those who were very religious for indicating they would find a mental health provider most effective in treating depressive symptoms.

## Correlations

The correlations among the demographic variables can be found in Table 4. Gender was found to be negatively correlated with education and prestige. Education was found to be negatively correlated with physician visits and health status. A positive correlation was found between prestige score and education. A positive correlation was found between health status and physician visits.

## Multiple Variable Analyses

A multiple regression analysis was conducted for each of the dependent measures of utilization in which multiple variables were significant predictors when tested individually. This included past utilization for the Baby Boomers and the future situational measures of utilization for the older adult cohort. Due to the high correlation between education and occupational prestige (See Table 4), only education was included, as an estimate of socioeconomic status in these equations.

For the Baby Boomers, a logistic regression analysis was conducted using gender, education, religiosity and physician visits to predict past mental health service utilization. As in the previous analyses, gender ($\underline{B}$ = -.94, $\underline{p}$<.01), education ($\underline{B}$ = .15, $\underline{p}$<.05) and physician visits ($\underline{B}$ = .18, $\underline{p}$<.01) predicted past utilization. However, religiosity was not a significant predictor in this equation. The odds of women having used services in the past was 2.5 times the odds for men. The odds ratio for education and physician visits were 1.16 and 1.20, respectively indicating that each was associated with an increase in the odds of past utilization.

For the older cohort group, separate logistic regression analyses used past utilization, religiosity and education to predict seeking help from a mental health provider

first for depressive symptoms and to predict whether a mental health provider would be regarded as most effective in treating depressive symptoms. Education was the only predictor of whether participants would go to a mental health provider first for depressive symptoms ($B = .16$, $p<.05$). In predicting whether participants would find a mental health provider effective in treating depressive symptoms, both religiosity ($B = -1.43$, $p<.05$) and education ($B = .16$, $p<.01$) were significant predictors. The odds ratio for education was 1.17 for both equations indicating a slight increase in the odds for positive responses on these questions was associated with each additional year of education. The predicted odds for people who were somewhat or not at all religious were approximately 4 times the odds for those people who were very religious for indicating a mental health provider would be most effective for depressive symptoms.

Cohort Differences in Treatment Fearfulness and Attitudes in Psychotherapy

Hypothesis three was not confirmed. T-tests revealed no significant differences between Baby Boomers and the older cohorts in attitudes towards psychotherapy or on any of the treatment fearfulness subscales. In addition, t-tests revealed no significant differences between Baby Boomers and older cohorts who had utilized mental health services in the past or between Baby Boomers and older cohorts who had not utilized mental health services in the past.

External Variables

To examine the external variables, regressions were conducted in which each external variable was tested individually as a significant predictor of each of the four measures of utilization. Logistic regression was used to test the external variables as predictors of past utilization and the situational measures. Simultaneous linear regression

was used to test the external variables as predictors of future likelihood of utilization. Past utilization was controlled for in all analyses of future utilization. Cost, transportation, Medicare, and knowledge of insurance were used as possible predictors. These were all categorical, yes/no variables. Due to the limited number of participants who did not have supplemental and Medicare insurance (N = 12), it was impossible to test hypothesis six and this variable was not included as a predictor. Descriptive information regarding each of the independent variables can be found in Table 5.

## Individual Variable Analyses

For the Baby Boomers, knowledge of insurance was found to predict positively past utilization ($\underline{B}$ = 1.74, $\underline{p}$<.05), future likelihood of utilization ($\underline{B}$ = 1.31, $\underline{p}$<.05), seeking a mental health provider first for depressive symptoms($\underline{B}$ = .93, $\underline{p}$<.05) and whether a mental health provider would be most effective in treating depressive symptoms ($\underline{B}$ = 1.21, $\underline{p}$<.05). The predicted odds for those who knew their insurance policy were 2-4 times the odds of those who did not know their policy for indicating they would seek help from a mental health provider first for depressive symptoms and that a mental health provider would be most effective for these symptoms. In addition, in predicting future likelihood of utilization, knowledge of insurance accounted for an additional 5% of the variance beyond what was predicted by past utilization alone. Cost, transportation and Medicare were not found to be significant predictors of any of the four measures of utilization.

For the older cohort group, knowledge of insurance predicted past ($\underline{B}$ = 1.32, $\underline{p}$<.05) and future likelihood of utilization ($\underline{B}$ = 1.37, $\underline{p}$<.05), but did not predict either situational measure. Medicare negatively predicted whether respondents would go to a

mental health provider first for depressive symptoms ($\underline{B}$ = -.86, $\underline{p}$<.05) and whether they believed a mental health provider would be most effective in treating depressive symptoms ($\underline{B}$ = -1.19, $\underline{p}$<.05). Cost and transportation did not predict any of the four measures of utilization. The predicted odds ratio indicated that those with Medicare were 2-3 times less than the odds for those without Medicare for reporting that a mental health provider would be the first provider they would seek help from and that a mental health provider would be most effective in treating depressive symptoms.

## Correlations

The correlations between the external variables are found in Table 6. Knowledge of insurance was negatively correlated with Medicare and positively correlated with cost being identified as a barrier. In addition, transportation and cost were positively correlated.

## Multiple Variable Analyses

Multiple regression analyses were not conducted for the external variables due to the fact that knowledge of insurance and Medicare were the only significant predictors and they did not both predict any one measure of utilization.

## Internal Barriers

To test the first five internal barrier hypotheses, a series of regression analyses were conducted for each of the dependent measures of utilization. The first set of analyses used each subscale of treatment fearfulness, memory controllability and aging concerns, as well as the variables of self-concealment, attitudes towards psychotherapy and depression as individual possible predictors for each of the four measures of utilization. Following these analyses, the correlations between the subscales for treatment

fearfulness, memory controllability and aging concerns were examined and regression analyses were conducted using all the subscales of these variables simultaneously as predictors of each of the four dependent variables. Since these variables are new, these analyses were conducted to test for suppression effects, in which a subscale may not have been a significant independent predictor, but would be significant in the presence of the other subscales. Following these analyses, final regression analyses were performed in which all of the internal variables found to be significant in the previous analyses were tested together as predictors of each of the four measures of utilization. Past utilization was controlled for in all analyses of future utilization. Descriptive statistics are found for all of the internal variables in Table 7.

## Individual Variable Analyses

### Treatment Fears

For the Baby Boomers, image concerns ($\underline{B}$ = -.064, $\underline{p}$<.05) and coercion concerns ($\underline{B}$ = -.12, $\underline{p}$<.05) individually predicted past utilization and future likelihood of utilization (Image Concerns, $\underline{B}$ = -.07, $\underline{p}$ <.05; Coercion concerns, $\underline{B}$ = -.13, $\underline{p}$ <.05). For predicting past utilization, the odds ratios for image concerns and coercion concerns were .82 and .87 respectively, indicating that each increase in score on these subscales was related to a decreased likelihood of past utilization. Image concerns was found to predict an additional 2% of the variance beyond past utilization alone for future utilization. Coercion concerns predicted an additional 3.5% of the variance. None of the scales of treatment fearfulness predicted either of the situational measures of utilization. Therapist responsiveness and stigma concerns did not predict any of the four measures of utilization.

For the older adult group, therapist responsiveness predicted future likelihood of seeking services, $\underline{B} = .05$, $\underline{p} < .05$. Therapist responsiveness accounted for 3% of the variance beyond past utilization in predicting future utilization. Contrary to hypothesis number eight, this variable positively rather than negatively predicted service use. Therapist responsiveness accounted for an additional 3% of the variance in future likelihood of utilization, beyond what was predicted by past utilization alone. Image concerns ($B = -.07$, $p<.05$) and stigma concerns ($B = -.05$, $p<.05$) predicted seeking help from a mental health provider first for depressive symptoms. The odds ratios for image concerns and stigma concerns were .93 and .95 respectively, indicating that for each increase in score on these subscales there was a small decrease in the likelihood of future utilization. None of the scales of treatment fearfulness predicted past utilization, future likelihood of utilization or whether a mental health provider would be most effective. Therapist responsiveness and coercion concerns were not significant predictors of any of the four measures of utilization.

The four subscales of treatment fearfulness were found to be highly correlated. Table 8 has the correlations between the four subscales as well as the correlations between treatment fears and memory controllability. All subscales were positively correlated with r values ranging from .34 to .74. Additional regression analyses were conducted using all four subscales of treatment fearfulness to predict the four measures of utilization.

For the Baby Boomers, coercion concerns, $\underline{B} = -.12$, $\underline{p}<.05$, negatively predicted past utilization. In addition, coercion concerns negatively, $\underline{B} = -.14$, $\underline{p} < .01$, and therapist responsiveness positively, $\underline{B} = .05$, $\underline{p} < .05$ predicted future likelihood of utilization. For

predicting past utilization, the odds ratio for coercion concerns was .89, indicating that each increase on the score for this subscale was associated with a decrease in the likelihood having sought services in the past. The subscales of treatment fearfulness accounted for an additional 6% of the variance for future likelihood of utilization beyond what was accounted for by past utilization alone.

For the older adult group, therapist responsiveness positively predicted past utilization, B = .07, p<.05. In predicting past utilization, the odds ratio for therapist responsiveness was 1.07. In addition, therapist responsiveness (B = .07, p <.01) positively predicted future utilization. Coercion concerns, B= -.20, p <.01, negatively predicted future likelihood of utilization. The subscales of treatment fearfulness accounted for an additional 7% of the variance for future likelihood of utilization beyond what was accounted for by past utilization alone.

Memory Controllability

For the Baby Boomers, potential improvement, B = .15, p<.05, and effort utility, B = .16, p<.01 positively predicted seeking help from a mental health provider first for depressive symptoms. Odds ratios for these variables were 1.16 and 1.18 respectively, supporting the regression analyses. None of the subscales of memory controllability predicted past utilization, future likelihood of utilization, or responses regarding a mental health provider as most effective in treating depressive symptoms. For the older adult cohort, none of the subscales of memory controllability individually predicted any of the four measures of utilization.

Correlations among the subscales of memory controllability are shown in Table 8. Present ability was positively correlated with potential improvement and effort utility and

negatively correlated with inevitable decrement. Effort utility was also positively correlated with potential improvement and negatively correlated with inevitable decrement. Potential improvement and inevitable decrement were negatively correlated.

Regression analyses were then performed using all four subscales of memory controllability simultaneously as predictors for all measures of utilization. For the Baby Boomers, present ability negatively predicted past utilization, $\underline{B} = -.11$, $\underline{p}<.05$. The odds ratio for present ability was .90, which suggests a modest decrease in the likelihood of past utilization for each increase in score on the present ability subscale. None of the memory controllability subscales predicted future likelihood of utilization or either of the situational measures of future utilization.

For the older adult group, inevitable decline negatively predicted future service utilization, $\underline{B} = -.14$, $\underline{p} <.05$. The memory controllability subscales accounted for an additional 4% of the variance beyond what was accounted for by past utilization alone in this equation. In addition, inevitable decline positively predicted the older adult cohorts indicating that a mental health provider would be the most effective, $\underline{B} = .18$, $\underline{p}<.05$. In predicting these responses, the odds ratio was 1.19.

Aging Concerns

For the Baby Boomers, independence, $\underline{B} = .14$, $\underline{p} <.05$, positively predicted future likelihood of service utilization. Independence accounted for an additional 2% of the variance beyond the variance accounted for by past utilization alone. Alzheimer's likelihood did not predict any of the four measures of utilization. Neither of these variables predicted any of the four measures of utilization for the older adult group. The correlation between Alzheimer's likelihood and independence was significant, $\underline{r} = -.43$,

p<.01. An additional regression analysis was run for each of the measures of utilization using both independence and Alzheimer's likelihood as predictors. Independence positively predicted future likelihood of service utilization for the Baby Boomers only, B = .17, p <.05. The subscales of the aging concerns scale accounted for an additional 3.5% of the variance for future utilization beyond what was accounted for by past utilization alone.

Self-Concealment

For the Baby Boomers, self-concealment negatively predicted future likelihood of seeking services, B = -.05, p <.01. Self-concealment accounted for an additional 2.7% of the variance for future utilization beyond that accounted for by past utilization alone. In addition, it positively predicted participants' assertions that they would go to a mental health provider first for depression symptoms, B = .08, p<.05. The odds ratio in predicting these responses was 1.07, indicating a small increase in the likelihood of participants indicating they would seek help from a mental health provider first for depressive symptoms. Self-concealment did not significantly predict any of the four measure of utilization for the older adult group.

Attitudes towards psychotherapy

For the Baby Boomers, attitudes towards psychotherapy predicted past utilization (B = .28, p <.05), future likelihood of seeking services (B = .23, p <.05), and participants' responses regarding whether a mental health provider would be most effective in treating depressive symptoms (B = .13, p<.05). Attitudes towards psychotherapy accounted for an additional 18% of the variance for future likelihood of utilization beyond what was accounted for by past utilization alone. The odds ratio in predicting past utilization was

1.32 and in predicting responses regarding whether a mental health provider would be most effective was 1.14. Attitudes towards psychotherapy did not predict participants responses regarding whether they would seek help from a mental health provider first for depressive symptoms.

For the older cohort group attitudes towards psychotherapy predicted past utilization ($\underline{B}$ = .17, $\underline{p}$<.05), future likelihood of seeking services ($\underline{B}$ = .22, $\underline{p}$ <.05), and participants responses to whether they would find a mental health provider most effective for treating depressive symptoms ($\underline{B}$ = .10, $\underline{p}$<.05). Attitudes towards psychotherapy accounted for an additional 28% of the variance in predicting future likelihood of utilization beyond what was accounted for by past utilization alone. The odds ratio was 1.18 in predicting past utilization and 1.11 in predicting responses regarding mental health providers' effectiveness.

Depressive symptoms

Significant depressive symptoms were defined as a score of 4 or more on the Geriatric Depression scale. For the Baby Boomers, significant depressive symptoms positively predicted past mental health service utilization ($\underline{B}$ = .87, $\underline{p}$ <.05), and negatively predicted future likelihood of seeking services for the Baby Boomers, ($\underline{B}$ = -1.11, $\underline{p}$ <.05). Depressive symptoms contributed an additional 2.1% of variance beyond that accounted for by past utilization in predicting future utilization. The predicted odds for those who are currently experiencing depression having sought past mental health services were approximately 2.5 times the odds for those who are not currently experiencing these symptoms. For the older adult group, depressive symptoms did not predict any of the measures of utilization.

## Correlations

Prior to examining regression analyses combining the significant internal variables, the relationship between these variables was examined using correlations. The correlations between treatment fearfulness subscales and memory controllability subscales are found in Table 8. Table 9 contains the correlations for these barriers with all other internal barriers. Treatment fears, memory controllability, aging concerns, attitudes towards psychotherapy and depression all appeared to be significantly related. Significant correlations were found ($r$ values range from .11 to .37) between self-concealment, attitudes towards psychotherapy, depression, and many of the subscales of the treatment fearfulness, memory controllability, and aging concerns subscales.

## Multiple Variable Analyses

A multiple regression analysis was conducted for each of the dependent measures of utilization in which multiple individual variables had been found to be significant predictors. This included analysis of all four dependent variables for the older adult group and three of the four for the Baby Boomers. Logistic regression was used for the analyses predicting past utilization and the situational measures of future utilization and linear regression was used for the analyses predicting future likelihood of utilization. Past utilization was controlled for in all analyses of future utilization.

For the Baby Boomers, image concerns, coercion concerns, present ability, attitudes towards psychotherapy and depressive symptoms were used to predict past utilization. Attitudes towards psychotherapy ($B = .29$, $p<.01$) and depressive symptoms ($B = 1.57$, $p<.05$) were the only significant predictors of past utilization in this equation. The predicted odds ratio for attitudes predicting past utilization was 1.33 indicating that

the odds of having used past services increased by 33% for each increase in score on the attitudes towards psychotherapy scale. In predicting past utilization, the odds of those who were experiencing depressive symptoms having used psychological services in the past was approximately 5 times greater than those who were not experiencing these symptoms.

For the older adult group, therapist responsiveness and attitudes towards psychotherapy were used to predict past utilization. Attitudes towards psychotherapy ($\underline{B}$ = .17, $\underline{p}$<.01) alone predicted past utilization. The odds ratio for attitudes towards psychotherapy was 1.19, indicating a significant increase in the odds of past utilization of services for each increase in score on the attitudes towards psychotherapy scale.

For the Baby Boomers, image concerns, coercion concerns, therapist responsiveness, independence, self-concealment, attitudes towards psychotherapy, and depressive symptoms were used to predict future likelihood of utilization. Therapist responsiveness ($\underline{B}$ = .05, $\underline{p}$ <.05) and attitudes towards psychotherapy ($\underline{B}$ = .20, $\underline{p}$ <.01) significantly predicted future likelihood of utilization. The internal variables included in this equation accounted for 22% additional variance for future utilization beyond what was predicted by past utilization alone.

For the older adult group, therapist responsiveness, coercion concerns, inevitable decrement and attitudes towards psychotherapy were used to predict future utilization. Attitudes towards psychotherapy predicted future utilization ($\underline{B}$ = .22, $\underline{p}$ <.01). The internal barriers included in this equation accounted for an additional 30% of the variance beyond what was accounted for by past utilization alone.

For the Baby Boomers, potential improvement, effort utility and self-concealment were used to predict participants' responses regarding whether participants would go to a mental health provider first for depressive symptoms. Self-concealment ($\underline{B}$ = .08, $\underline{p}$<.01) significantly predicted these responses. The odds ratio for self-concealment was 1.08, indicating a small increase in the odds of positive responses to this question for each increase in score on the self-concealment scale.

For the older adult group, image concerns and stigma concerns were used to predict participants' responses regarding whether participants would go to a mental health provider first for depressive symptoms. Neither of these significantly predicted responses.

For the Baby Boomers, attitudes towards psychotherapy alone was found to be significant in predicting participants responses to who would be most effective in treating depressive symptoms. Thus, a multiple variable regression equation was not performed for this dependent variable.

For the older adult group, inevitable decline and attitudes towards psychotherapy were used to predict participants' responses for who would be most effective in treating depressive symptoms. Both inevitable decline ($\underline{B}$ = .15, $\underline{p}$<.01) and attitudes towards psychotherapy ($\underline{B}$ = .13, $\underline{p}$<.01) significantly predicted responses to this question. Odds ratios for inevitable decline and attitudes towards psychotherapy were: 1.17 and 1.14, respectively. This indicates that a significant increase in the likelihood of participants indicating a mental health provider would be effective for depressive symptoms was associated with each one point increase on these scales.

T-Tests Comparing Depressed versus Non-depressed Individuals

For the Baby Boomers, t-tests revealed that depressed individuals (GDS Score of 4 of more) scored significantly higher than non-depressed individuals on the treatment fearfulness scales of image concerns, $t$ (183) = -3.00, $p$ <.05 and stigma concerns, $t$ (182) = -2.99, $p$ <.05. In addition, depressed individuals scored significantly lower than non-depressed individuals on the memory controllability scales of present ability, $t$ (180) = 5.47, $p$ <.01, potential improvement, $t$ (182) = 2.08, $p$ <.05 and beliefs of maintaining independence, $t$ (180) = 3.25 , $p$ <.05. These individuals also scored higher on the aging concern scale regarding the likelihood of Alzheimer's disease, $t$ (182) = -2.70, $p$ <.05. A t-test revealed that depressed individuals did not significantly differ from non-depressed individuals in their attitudes regarding psychotherapy.

For the older cohorts, t-tests revealed no difference between depressed and non-depressed individuals on the treatment fearfulness scales. However, depressed individuals scored significantly lower than non-depressed individuals on the memory controllability scales of present ability, $t$ (145) = 3.24, $p$ <.01, potential improvement, $t$ (145) = 4.21, $p$ <.01, effort utility, $t$ (148) = 2.01, $p$ <.05, and beliefs of maintaining independence with aging, $t$ (180) = 4.04 , $p$ <.01. These individuals scored significantly higher on the memory controllability scale regarding the inevitable decline, $t$ (149) = - 5.22, $p$ <.01. Depressed individuals did not differ from non-depressed in their attitudes regarding psychotherapy. The means and standard deviations for those who were experiencing significant depressive symptoms and those who were not can be found in Table 10 for each cohort group for all scales of treatment fearfulness, memory controllability and aging concerns and attitudes towards psychotherapy.

Exploratory Analyses: Combining Demographic, Internal, and External Barriers

Regression analyses were conducted using the significant demographic, external and internal barriers for each cohort group to predict the four measures of utilization. Prior to conducting these analyses, the correlations between the significant factors, which included gender, education, physician visits, religiosity, knowledge of insurance, Medicare, therapist responsiveness, inevitable decrement, depressive symptoms, and attitudes towards psychotherapy, were examined. These can be seen in Table 11. These analyses allowed for the strength and uniqueness of the variables from each set (demographic, internal and external) to be compared to variables from the other sets. As in all analyses, past utilization was included in all analyses of future utilization. In addition, separate equations were used for the Baby Boomers and older adult group due to the fact different variables had been found to be significant for each group. Results of the logistic regression analyses of the demographic, external and internal variables for past utilization and the situational measures of future utilization can be found in Table 12 and results of the simultaneous linear regression analysis for future utilization can be found in Table 13.

For the Baby Boomers, a logistic regression analysis used gender, education, physician visits, knowledge of insurance policy, depression and attitudes towards psychotherapy to predict past utilization. Physician visits, knowledge of insurance, depressive symptoms, and attitudes towards psychotherapy positively predicted past utilization. Odds ratios for physician visits and attitudes towards psychotherapy were 1.21 and 1.28, respectively. For predicting past utilization, the odds for depressed individuals having used services in the past was approximately 4 times greater than the

odds for non-depressed individuals. In addition, the odds of those who knew their insurance policy having used psychological services in the past was approximately 3 times greater than the odds of those who did not know their policy. Gender and education were not significant in predicting past utilization.

For the older cohort group, a logistic regression used knowledge of insurance and attitudes towards psychotherapy to predict past utilization. Attitudes toward psychotherapy and knowledge of insurance predicted past utilization for the older cohort group. The odd ratio for attitudes towards psychotherapy was 1.15. The odds of those who knew their insurance policy have used psychological services in the past were approximately 3 times greater than the odds of those who did not know their policy.

For the baby boomers, knowledge of insurance, therapist responsiveness, and attitudes towards psychotherapy were used to predict future likelihood of utilization. Knowledge of insurance and attitudes towards psychotherapy positively predicted future likelihood of utilization for the Baby Boomers. This equation accounted for 53% of the variance associated with future utilization.

For the older cohort group, knowledge of insurance and attitudes towards psychotherapy were used to predict future likelihood of utilization. Attitudes towards psychotherapy predicted future likelihood of service utilization. Knowledge of insurance did not predict future likelihood of utilization in this equation.

For the Baby Boomers, a logistic regression analysis used past utilization, health status, knowledge of insurance, and self-concealment to predict participants' responses on whether they would seek help from a mental health provider first for depressive symptoms. Self-concealment, knowledge of insurance, and health status positively

predicted responses to this question. The odds ratio for self-concealment was 1.07. For predicting participants indicating that they would seek help first from a mental health provider, the odds of those who knew their insurance policy was approximately 2.5 times greater than the odds of those who did not know their policy. In addition, the odds of those who rated their health status as excellent was approximately 2.5 times greater than the odds of those who did not rate their health as excellent or good.

For the older adult group, education and Medicare were used to predict participants' responses on whether they would seek help from a mental health provider first for depressive symptoms. Neither of these variables predicted responses.

For the Baby Boomers, a logistic regression analysis used past utilization, knowledge of insurance and attitudes towards psychotherapy to predict participants' responses on whether they would find a mental health provider most effective in treating depressive symptoms. Attitudes towards psychotherapy and knowledge of insurance positively predicted participants' responses. The odds ratio for attitudes towards psychotherapy was 1.14. In addition, in predicting participants indicating a mental health provider would be most effective in treating depressive symptoms, the odds for those who knew their insurance policy were 3 times as great as the odds for those who did not know their policy.

For the older adult group, past utilization, education, religiosity, Medicare, inevitable decrement of memory, and attitudes towards psychotherapy were used to predict participants' responses on whether they would seek help from a mental health provider first for depressive symptoms. Medicare negatively predicted participants indicating they would go to a mental health provider first for depressive symptoms. In

predicting positive responses to this question, the odds of those individuals without Medicare were 6 times greater than those with Medicare. Attitudes towards psychotherapy and beliefs in inevitable decrement of memory positively predicted participants indicating they would go to a mental health provider first for depressive symptoms. Odds ratio for attitudes towards psychotherapy and inevitable decline were 1.20 and 1.22 respectively, indicating a significant increase in the odds for a positive response to this question for each increase in score on these scales. Past utilization, included as a control factor, was not found to be a significant predictor in this analysis.

Table 2

Individual and Suppressed Predictors of Mental Health Service Utilization for the Baby Boomers

| | Dependent Measures of Utilization | | | |
|---|---|---|---|---|
| INDEPENDENT VARIABLES | Past Utilization | Future Likelihood | MHP First For Depression | MHP Effective For Depression |
| Past Utilization | --- | Significant | Significant | Significant |
| Gender | Significant | --- | --- | --- |
| Occupational Prestige | Significant | --- | --- | --- |
| Education | Significant | --- | --- | --- |
| Religiosity | Significant | --- | --- | --- |
| Health Status | --- | --- | Significant | --- |
| Physician Visits | Significant | --- | --- | --- |
| Transportation | --- | --- | --- | --- |
| Cost | --- | --- | --- | --- |
| Medicare | --- | --- | --- | --- |
| Knowledge of Insurance | Significant | Significant | Significant | Significant |
| Treatment Fears | | | | |
| Therapist Resp. | Significant | --- | --- | --- |
| Image Concerns | Significant | --- | --- | --- |
| Coercion Concerns | Significant | --- | --- | --- |
| Stigma Concerns | --- | --- | --- | --- |
| Memory | | | | |
| Controllability | | | | |
| Present Ability | Significant | --- | --- | --- |
| Potential Improvement | --- | --- | Significant | --- |
| Effort Utility | --- | --- | Significant | --- |
| Inevitable Decrement | --- | --- | --- | --- |
| Aging Concerns | | | | |
| Independence | --- | Significant | --- | --- |
| Alzheimer's Likelihood | --- | --- | --- | --- |
| Self-Concealment | --- | Significant | Significant | |
| Attitudes Towards Psychotherapy | Significant | Significant | --- | Significant |
| Depressive Symptoms | Significant | Significant | --- | --- |

Table 3

Individual and Suppression Effect Predictors of Mental Health Service Utilization for the Older Cohort Group

| | Dependent Measures of Utilization | | | |
|---|---|---|---|---|
| INDEPENDENT VARIABLES | Past Utilization | Future Likelihood | MHP First For Depression | MHP Effective For Depression |
| Past Utilization | --- | Significant | Significant | Significant |
| Gender | --- | --- | --- | --- |
| Occupational Prestige | --- | --- | Significant | --- |
| Education | --- | --- | Significant | Significant |
| Religiosity | --- | --- | Significant | Significant |
| Good Health | --- | --- | --- | --- |
| Physician Visits | --- | --- | --- | --- |
| Transportation | --- | --- | --- | --- |
| Cost | --- | --- | --- | --- |
| Medicare | --- | --- | Significant | Significant |
| Knowledge of Insurance | Significant | Significant | --- | --- |
| Treatment Fears | | | | |
| Therapist Resp. | Significant | Significant | --- | --- |
| Image Concerns | --- | --- | Significant | --- |
| Coercion Concerns | --- | Significant | --- | --- |
| Stigma Concerns | --- | --- | Significant | --- |
| Memory | | | | |
| Controllability | | | | |
| Present Ability | --- | --- | --- | --- |
| Potential Improvement | --- | --- | --- | --- |
| Effort Utility | --- | --- | --- | --- |
| Inevitable Decline | --- | Significant | --- | Significant |
| Aging Concerns | | | | |
| Independence | --- | --- | --- | --- |
| Alzheimer's Likelihood | --- | --- | --- | --- |
| Attitudes Towards Psychotherapy | Significant | Significant | --- | Significant |
| Depressive Symptoms | --- | --- | --- | --- |

Table 4

Correlations Among Demographic Variables

| | Health | Physician Visits | Religiosity | Education | Prestige |
|---|---|---|---|---|---|
| Gender | .02 | -.03 | -.09 | -.15** | -.14* |
| Prestige | - .05 | -.06 | -.01 | .48** | |
| Education | - .16** | -.13* | .03 | | |
| Religiosity | - .04 | -.07 | | | |
| Physician Visits | .26** | | | | |

*p<.05
**p<.01

Table 5

Responses for External Variables

| | Baby Boomers | | Older Adults | |
|---|---|---|---|---|
| External Variables | % Yes | % No | % Yes | % No |
| Transportation a Barrier to service | 1.7 | 98.3 | 1.4 | 98.6 |
| Cost a barrier to service | 12.2 | 88.8 | 5.8 | 94.2 |
| Know Insurance Policy for Mental Health | 48.9 | 51.1 | 28.3 | 71.7 |
| Have Medicare | 5.0 | 95.0 | 68.1 | 32.9 |
| Have Supplemental Insurance | 88.2 | 11.8 | 85.6 | 14.4 |

Table 6

Correlations Among External Variables

| | Transportation | Cost | Knowledge | Medicare |
|---|---|---|---|---|
| Past Utilization | .02 | .15* | .38** | -.08 |
| Medicare | .02 | .003 | - .16 | |
| Knowledge | .001 | .13* | | |
| Cost | .12* | | | |

*p<.05
**p<.01

Table 7

Means and SD for Internal Variables By Cohort Group and Utilization of Services

| | Baby Boomers | | Older Cohorts | |
|---|---|---|---|---|
| | Utilized Services in Past | Have Not Utilized Past Services | Utilized Services in Past | Have Not Utilized Past Services |
| Treatment Fears | | | | |
| Therapist Responsiveness | 28.66 (9.26) | 28.42 (7.91) | 29.52 (9.06) | 26.42 (9.65) |
| Image Concerns | 12.61 (5.17) | 14.52 (5.86) | 12.87 (6.96) | 14.26 (7.38) |
| Coercion Concerns | 7.36 (3.19) | 8.98 (4.02) | 8.86 (4.77) | 9.21 (4.42) |
| Stigma Concerns | 19.19 (9.63) | 21.49 (9.91) | 19.17 (8.42) | 20.90 (10.62) |
| Memory Controllability | | | | |
| Present Ability | 20.85 (5.45) | 21.73 (4.46) | 21.34 (4.95) | 21.24 (4.26) |
| Potential Improvement | 16.30 (3.12) | 15.49 (3.18) | 15.56 (3.41) | 15.74 (3.84) |
| Effort Utility | 15.39 (3.69) | 14.39 (4.08) | 15.16 (3.46) | 15.46 (4.08) |
| Inevitable Decline | 9.79 (3.92) | 10.85 (3.65) | 11.68 (3.63) | 10.96 (4.10) |
| Aging Concerns | | | | |
| Independence | 14.74 (3.62) | 14.66 (3.08) | 14.22 (3.53) | 14.41 (3.70) |
| Alzheimer's Likelihood | 11.78 (5.01) | 11.87 (4.16) | 11.54 (4.78) | 11.72 (4.62) |
| Self-Concealment | 23.20 (9.23) | 22.46 (7.26) | 22.86 (9.29) | 20.54 (7.89) |
| Depression | 2.33 (2.87) | 1.28 (1.73) | 2.22 (2.25) | 1.47 (1.91) |
| Attitudes Towards Psychotherapy | 25.07 (4.57) | 18.83 (4.93) | 24.06 (5.69) | 18.83 (6.48) |

Table 8

Correlations Among Treatment Fearfulness and Memory Controllability Subscales

| | Inevit. Decline | Effort Utility | Potent. Improve. | Present Ability | Stigma Concern | Coercion Concern | Image Concern |
|---|---|---|---|---|---|---|---|
| Therapist Response | -.01 | .13* | .08 | -.01 | .34** | .44** | .44** |
| Image Concerns | .22** | -.11* | -.25** | -.18** | .63** | .74** | |
| Coercion Concerns | .16** | -.04 | -.15** | -.07 | .55** | | |
| Stigma Concerns | .13* | -.09 | -.16** | -.16* | | | |
| Present Ability | -.36** | .34** | .58** | | | | |
| Potential Improve | -.51** | -.24** | | | | | |
| Effort Utility | -.24** | | | | | | |

*p<.05
**p<.01

Table 9

Correlations Among All Internal Barriers

| | Attitudes Towards Psych. | Depress. Symptoms | Self-Conceal | Alzheimer's Likelihood | Independence |
|---|---|---|---|---|---|
| Therapist Response | .12* | - .05 | .10 | .03 | - .08 |
| Image Concerns | - .19** | .14** | .21** | .11* | - .24** |
| Coercion Concerns | - .22** | .09 | .20** | .08 | - .18** |
| Stigma Concerns | - .11* | .12* | .20** | .18** | - .18** |
| Present Ability | .07 | - .33** | - .23** | - .38** | .51** |
| Potential Improve | .18** | - .24** | - .25** | - .27** | .47** |
| Effort Utility | .17** | - .14** | - .14* | - .02 | .22** |
| Inevitable Decline | - .17** | .24** | .23** | .35** | - .45** |
| Indepen-dence | .09 | - .28** | - .24 | - .43** | |
| Alzheimer's Likelihood | .06 | .17** | .09 | | |
| Self-Conceal | - .15** | .25** | | | |
| Depressive Symptoms | - .11 | | | | |

*p<.05
**p<.01

Table 10

Internal Variables By Cohort Group and Depressive Symptoms (GDS≥4)

| | Baby Boomers | | | | Older Cohorts | | | |
|---|---|---|---|---|---|---|---|---|
| | Depressed | | Not Depressed | | Depressed | | Not Depressed | |
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| Treatment Fears | | | | | | | | |
| Therapist Response | 29.11 | 9.33 | 28.46 | 8.26 | 24.35 | 9.64 | 27.64 | 9.49 |
| Image Concerns | 16.64 | 7.57 | 13.24 | 5.12 | 15.12 | 8.03 | 13.69 | 7.15 |
| Coercion Concerns | 9.46 | 3.68 | 8.14 | 3.78 | 9.64 | 5.20 | 8.98 | 4.33 |
| Stigma Concerns | 25.45 | 12.10 | 19.61 | 8.84 | 20.62 | 10.49 | 20.17 | 10.16 |
| Memory Controllability | | | | | | | | |
| Present Ability | 17.11 | 5.08 | 22.19 | 4.42 | 18.88 | 5.26 | 21.89 | 4.07 |
| Potential Improve Effort | 14.71 | 3.18 | 16.05 | 3.10 | 13.08 | 3.66 | 16.32 | 3.47 |
| Utility | 13.64 | 3.84 | 15.04 | 3.84 | 14.08 | 3.22 | 15.73 | 3.93 |
| Inevitable Decline | 11.32 | 4.23 | 10.35 | 3.65 | 14.50 | 3.98 | 10.39 | 3.58 |
| Aging Concerns | | | | | | | | |
| Independence | 12.81 | 3.58 | 15.01 | 3.17 | 11.88 | 4.77 | 14.94 | 3.20 |
| Alzheimer's Likelihood | 13.93 | 5.28 | 11.48 | 4.26 | 13.08 | 5.30 | 11.41 | 4.50 |
| Self-Concealment | 28.18 | 10.03 | 21.72 | 7.27 | 24.96 | 8.45 | 20.15 | 8.14 |
| Depression (GDS Total) | 6.21 | 2.34 | .88 | .95 | 5.27 | 1.85 | .91 | .99 |
| Attitudes Towards Psychotherapy | 20.33 | 6.20 | 21.41 | 5.58 | 17.88 | 6.97 | 20.40 | 6.53 |

Table 11

Correlations Among Significant Demographic, External and Internal Variables

| | Medicare | Knowing Insurance | Religiosity | Physician Visits | Educ. | Gender |
|---|---|---|---|---|---|---|
| Therapist Response | .08 | .08 | -.10 | .02 | .03 | .02 |
| Self-Concealment | .12* | .07 | .05 | .04 | .05 | -.05 |
| Inevitable Decrement | -.09 | -.20** | .05 | .14 | -.20 | -.10 |
| Depressive Symptoms | -.13* | .05 | .02 | .19** | -.16** | .08 |
| Attitudes Towards Therapy | .04 | .35** | -.07 | .02 | .14** | .11 |
| Gender | .07 | .08 | -.09 | -.03 | -.15** | --- |
| Education | .30** | .19** | .03 | -.13* | --- | --- |
| Physician Visits | -.24** | .02 | -.07 | --- | --- | --- |
| Religiosity | .13* | .01 | --- | --- | --- | --- |
| Knowing Insurance | -.16** | --- | --- | --- | --- | --- |

*p<.05
**p<.01

Table 12

Logistic Regression Analyses of Demographic, External and Internal Barriers

| Predictors | Baby Boomers | | | | Older Cohorts | | | |
|---|---|---|---|---|---|---|---|---|
| | N | B | SE | Exp(B) | N | B | SE | Exp(B) |
| **Past Mental Health Service Utilization** | | | | | | | | |
| Gender | 177 | -.62 | .45 | .54 | --- | --- | --- | --- |
| Education | 177 | .09 | .08 | 1.10 | --- | --- | --- | --- |
| Physician Visits | 177 | .19* | .09 | 1.21 | --- | --- | --- | --- |
| Knowing Insurance | 177 | 1.04* | .41 | 2.83 | 146 | .97* | .44 | 2.65 |
| Depression | 177 | 1.34* | .58 | 3.82 | --- | --- | --- | --- |
| Attitudes Towards Therapy | 177 | .25** | .05 | 1.28 | 146 | .14** | .05 | 1.15 |
| **Mental Health Provider First For Depressive Symptoms** | | | | | | | | |
| Past Utilization | 170 | 1.71* | .41 | 5.53 | 141 | 1.46* | .44 | 4.31 |
| Education | --- | --- | --- | --- | 141 | .13† | .08 | 1.14 |
| Health Status | 170 | .94* | .40 | 2.55 | --- | --- | --- | --- |
| Medicare | --- | --- | --- | --- | 141 | -.66 | .44 | .52 |
| Knowing Insurance | 170 | .90* | .39 | 2.47 | --- | --- | --- | --- |
| Self-Concealment | 170 | .07* | .02 | 1.08 | --- | --- | --- | --- |
| **Mental Health Provider Most Effective For Depressive Symptoms** | | | | | | | | |
| Past Utilization | 165 | 2.08† | 1.09 | 8.00 | 133 | .81 | .65 | 2.25 |
| Education | --- | --- | --- | --- | 133 | .10 | .10 | 1.11 |
| Religiosity | --- | --- | --- | --- | 133 | -.89 | .50 | .41 |
| Medicare | --- | --- | --- | --- | 133 | -1.60* | .58 | .20 |
| Knowing Insurance | 165 | 1.11* | .56 | 3.03 | --- | --- | --- | --- |
| Inevitable Decline | --- | --- | --- | --- | 133 | .20** | .06 | 1.22 |
| Attitudes Towards Therapy | 165 | .12* | .05 | 1.13 | 133 | .19* | .05 | 1.20 |

†$p<.10$. *$p<.05$. **$p<.01$.

Table 13

Simultaneous Regression Analysis of Demographic, External and Internal Barriers For Future Utilization By Cohort Group

| | Baby Boomers[1] | | | | Older Cohort Group[2] | | | |
|---|---|---|---|---|---|---|---|---|
| Predictors | N | B | SE | β | N | B | SE | β |
| Past Utilization | 173 | 1.34 | .34 | .25** | 140 | .88 | .44 | .14* |
| Knowing Insurance | 173 | .87 | .31 | .17** | 140 | .76 | .41 | .13 |
| Therapist Response. | 173 | .03 | .02 | .10† | 140 | --- | --- | --- |
| Attitudes Towards Therapy | 173 | .21 | .03 | .46** | 140 | .21 | .03 | .53** |

[1] $R^2$ = .32 (Past Utilization Alone), $R^2$ = .53 (All variables)
[2] $R^2$ = .14 (Past Utilization Alone), $R^2$ = .42 (All variables)

†p<.10. *p<.05. **p<.01. ***p<.001.

# CHAPTER IV

# DISCUSSION

The purpose of this research was to explore barriers to mental health services for middle aged and older adults. Although the current literature continues to document the lack of sufficient utilization of services by those over age 65 (Arean et al., 2002; Qualls et al., 2002; Rogers & Barusch, 2000), there has been a lack of clarity regarding which barriers are significant in predicting utilization. Specifically, the goal of this study was to examine a wide breadth of demographic, external, and internal barriers identified in past literature, as well as to explore the new barriers of treatment fearfulness, self-concealment, aging concerns and memory controllability. In addition, the study provided an opportunity to add descriptive information not existing in the literature on mental health service utilization and barriers to service.

Prior to considering service barriers, the relationship between past and future utilization and the difference in utilization between the cohort groups was examined. In general, the sample reported a higher rate of mental health service utilization and high likelihood of future utilization than has been reported in past literature, especially for those individuals over the age of sixty-five (Qualls et al., 2002). A discrepancy was found between results that suggested most participants believed mental health providers would be effective in treating depression but that many would not report depressive symptoms to a mental health provider first. This finding is consistent with results that most individuals prefer to seek help from their primary care doctor for psychological symptoms (Arean et al., 2002). People are familiar with their medical doctors and may feel most comfortable seeking help first from these professionals. However, they may

also seek help from a physician first due to the fact their insurance may require a referral from their primary care doctor to seek mental health services.

In this study, past utilization of mental health services significantly predicted future likelihood of seeking services in almost all analyses. Consistent with the literature in which approximately 80% of those who seek mental health services describe their treatment as successful (Hubble, Duncan, & Miller, 1999), this finding suggests that past service users are satisfied with their treatment and thus, are willing to consider utilizing services in the future. Given the high level of satisfaction reported by service users, it is all the more important to identify barriers which interfere with seeking services for the first time. Thus, past utilization was controlled for in all analyses in an attempt to identify which barriers are significant regardless of past service use.

Differences were found between the cohort groups in service utilization, suggesting that studies which aim to identify service barriers must consider the cohort composition of the sample. Many studies simply discuss those over the age of 55 or 65 as a homogenous group, and judging from the present findings, this may explain why consistent results on utilization barriers are difficult to find in the literature. Closer attention to which findings apply to which specific cohort groups is necessary to increase the utility and consistency of the research on barriers to utilization.

In the analyses of the hypothesized barriers, several variables emerged as unique predictors of utilization even when all other significant individual barriers were controlled for. For the Baby Boomers these variables include: health status, physician visits, knowledge of insurance, depression, therapist responsiveness, self-concealment, and attitudes towards psychotherapy. For the older adult cohort group these variables

include: Medicare (having Medicare), the belief in inevitable decrement in memory, attitudes towards psychotherapy and knowledge of insurance. The findings support the notion that demographic, external, and internal factors uniquely impact service utilization and vary by cohort group. For example, none of the demographic factors significantly predicted utilization for the older adult group. In contrast, several of these factors were important for the Baby Boomers. In addition, consistencies can be seen across the groups. Knowledge of insurance and attitudes towards psychotherapy were important predictors for both cohort groups.

In addition, the results suggest that the format and type of question must be considered when measuring mental health care utilization. That is, different patterns of predictors were seen for past utilization, future likelihood of utilization and the situational measures of utilization. It is clear that there is a difference between people's past utilization behavior, their general openness to services in the future and their openness to services when given a specific situation to imagine.

The results from the separate analyses of each individual predictor are as important to consider as those analyses combining the demographic, internal and external barriers. That is, an effort to improve utilization may be made using one variable alone, using all demographic or external or internal variables, or an effort may be made by using all three areas. The findings for each hypothesized variable are briefly discussed in order to explore the role each may or may not play a role in utilization for a given cohort group and to provide explanations that may apply help improve services for middle aged and older adults.

## Demographic Barriers

Gender, socioeconomic status, religiosity, health status, and physician visits were tested as individual factors in service utilization. While several of the demographic factors predicted utilization for the Baby Boomers, only education and religiosity predicted utilization for the older cohort. Despite differences in utilization, the cohort groups were not found to differ in attitudes towards psychotherapy or treatment fears.

### Gender

Consistent with current literature which has found gender differences in middle aged and younger samples (Rhodes, 2000), Baby Boomer women reported a significantly higher rate of past mental health service utilization than men. Gender did not predict utilization for the older cohort group. The literature on gender differences in depression and aging may relate to these findings. In a recent longitudinal study, Barefoot and colleagues (2001) tracked depression over a thirty-year period and found that men showed increases in depressive symptoms from ages 60 to 80, but women did not. Thus, while the gender difference in past utilization may be explained by a higher rate of depression early in life for women, the similarity in future likelihood may to related to Baby Boomer men experiencing increased distress and a need for psychological services as they face the challenges of aging.

For the older cohort, the decision not to seek services in the past may have been based on the social stigma at that time regarding mental health services. Thus, although data on gender differences in depression would suggest that older women are more likely than men to have been depressed, both older men and women may have been hesitant to seek services, regardless of whether or not they experienced depression. In addition,

given the results presented by Barefoot and colleagues (2001), men and women in the older cohort are likely to be experiencing similar levels of depression, and thus may be similar in their needs for seeking services.

### Socioeconomic Status: Education and Occupational Prestige

While some support was found for the hypothesis that education and occupational prestige would predict utilization, these factors accounted for a small portion of the variance. Socioeconomic variables may not interfere with utilization for this sample to a great degree, given that very few individuals had less than high school education or reported occupations from the least prestigious occupational groups.

The fact that socioeconomic factors predicted past utilization for the Baby Boomers, but not the future utilization measures suggests that for the Baby Boomers, those in lower SES groups may possess knowledge and a desire to use psychological services, but because of their financial situation may have limited access to mental health services. This is consistent with literature which documents that despite a need and desire for services, adequate mental health services are not available for many individuals in lower SES groups (Hannon & Roth, 2001).

In contrast, for the older adults, education was not predictive of past utilization, but was predictive of responses to the experience of depressive symptoms. Thus, socioeconomic factors may play a larger role in older adults' knowledge of psychological treatment, a factor which in turn directly impacts utilization (Lundervold & Young, 1992). Older individuals in lower SES groups may avoid services due to their lack of knowledge, rather than the lack of access to services they desire.

Religiosity negatively predicted utilization for the older cohort group, on the situational questions regarding the experience of depressive symptoms. For the Baby Boomers, religiosity was not a significant predictor when considered with all demographic variables, but individually was a positive predictor of utilization.

Research has suggested that religiosity may be associated with happiness in later life (Francis, Jones, & Wilcox, 2000). Thus, older adults who report being very religious may feel more positively about their lives and they are therefore better able to cope with depressive symptoms than those who are not as religious. The reluctance to use mental health services by very religious individuals may reflect their positive feelings about themselves rather than negative feelings about services. This explanation appeared to be supported by responses to the open-ended questions in which several participants, both in the older cohort group and in the Baby Boomer group, discussed the comfort of religion in their lives. For example, a fifty-year-old-female described her relationship with God when asked about psychotherapy, stating, "Knowing Jesus Christ as my personal lord and savior has made all the difference in my life...I am never alone. I can talk to him about anything and he is more than just a good listener. "

It may also be that generational differences in the coordination between religious leaders and mental health providers may explain why religiosity was positively related to utilization for Baby Boomers, but negatively related to utilization for older adults. In the past ten years, mental health providers have attempted to be more aware of spirituality and may encourage clients to seek out help from their ministers or priests (Shafranske, 2000; Yarhouse & Fisher, 2002). By the same token, priests and ministers have increased

collaboration with mental health providers and increased referrals for psychological counseling for those who come to them in need (Edwards, Lim, McMinn, & Dominguez, 1999). It may be that these referrals are more frequently given to Baby Boomers, and by younger religious leaders, due to stereotypes regarding aging or simply due to their unawareness of how psychological disorders appear in older adults. Thus, continued collaboration and efforts to increase religious leaders' awareness of psychological disorders in older adults could be a useful area to explore in improving utilization.

## Physician Visits

Physician visits positively predicted past utilization of psychological services for the Baby Boomers only. Assuming greater openness to mental health issues among these younger cohorts, it is possible that they may rely upon the assistance from their physician to help them address their psychological concerns and thus, may schedule more frequent appointments. It is interesting, however, that the number of physician visits is not related to future likelihood of seeking services. Those individuals who frequently seek help from their physician may have utilized past services, but may not have been satisfied or may not feel comfortable with seeking these services again. Thus, these individuals may require frequent encouragement from their physician to seek mental health services or they are likely to rely solely on the medical provider to address these concerns.

Alternatively, it may be that these individuals suffer more physical problems due to their lifestyle or to a major illness early in life. The fact that a significant negative relationship was found between health status and physician visits supports this explanation. Thus, these individuals may have accessed mental health services due to difficulties related to health behaviors (substance use, eating, exercise, etc) or medical

conditions which required to seek help both from their medical provider as well as a mental health provider.

Physician visits were not associated with the utilization of services for older adults. This finding may reflect the lack of referrals physicians make for psychological services for older adults. Although older adults are likely to be utilizing their primary care doctor to address their psychological as well as their medical concerns (Arean et al., 2002), they are unlikely to be encouraged by their physician to seek services to address these issues (Arean et al., 2001). Frequent physician visits may not be detected as being related to psychological issues in this population, whereas the frequency of such visits are related to psychological concerns in the Baby Boomers.

## Health Status

Baby Boomers who reported their health status as excellent were more likely to indicate that they would seek help first from a mental health provider for depressive symptoms. An interpretation of this finding is that those who view their health as "excellent" may have perceived the description of depressive symptoms in a different way than those who had less positive views of their health. It is possible that those with medical conditions were likely to perceive the depressive symptoms described as related to a medical condition. In contrast, those who view their health as excellent would be unlikely to relate these symptoms to medical illness and may have recognized these symptoms as related to depression. Those with medical conditions might perceive the symptoms as being related to their physical health and want to consult with a doctor first to rule out physical causes before consulting a mental health provider.

For older adults, it does not appear that health status is related to utilization of mental health services. Again, a consideration of the sample's make-up is important in interpreting these findings. Given that the majority of these older adults are living independently in their own homes, they may not be representative of the frailer portion of the older population. Older adults who are frail and report significant health problems have been found to be more likely to become depressed and less likely to receive mental health services (Rogers & Barusch, 2000). Thus, this portion of the older adult population may face more difficulties with accessing services than was true for this sample. In addition, older adults have been found to report few health and overall positive views of their health status (Whitbourne, 2001). Thus, even older adults who have health conditions which could interfere with accessing services, may have described their health as excellent.

### Cohort: Attitudes Towards Psychotherapy and Treatment Fears

Consistent with some recent literature, the attitudes of older adults towards therapy may be more positive than was previously thought (Landreville et al., 2001). It is surprising that older adults did not report more fears about treatment than Baby Boomers, given they have had less exposure to what treatment entails and have been found to have less knowledge about psychological treatment (Lundervold & Young, 1992). Several factors may account for this finding.

The first important issue to consider is that of the cohort's beliefs with regard to authority figures. The Baby Boomers came of age in a time when they were taught to question authority. Thus, in general, this cohort is open to reporting and expressing their concerns regarding those in positions of authority, including their medical providers

(Noble et al., in press). In contrast, the older cohort groups were raised in a time when they were taught to obey authority figures and not to express individual concerns (Schewe et al., 2000). Thus, it is possible the Baby Boomers may be simply more open in expressing their concerns than are those in the older cohort group, whom are hesitant to express these concerns.

The approach-avoidance model as described by Kushner and Sher (1989) in relation to mental health services may also be useful to consider in understanding the lack of treatment fears reported by older adults. Older individuals who have never used services may never imagine or approach utilizing services and thus, may not be aware of the fears they have about treatment. In contrast, Baby Boomers may be able to imagine treatment based on their own use of mental health services or familiarity with those who have used services. This ability to imagine service realistically is a form of approach, and thus, Baby Boomers may be more likely to expose themselves to the concerns they would have about treatment.

Several comments in the open-ended portion of the questionnaire support the notion that older adults simply have not considered how services may be helpful or relevant to them. Many older individuals responded with "No concern" to all of the treatment fearfulness questions which may have been due to their inability to imagine a situation in which they would seek services. In addition, in the open ended question on psychotherapy, a seventy-five-year-old woman stated, "I never gave much thought to psychiatrists or psychologists during my life." An 81-year-old male participant stated, "It's hard to give answers on psychotherapy, having never had any experience." In the section where participants were asked to indicate what they found confusing on the

questionnaire, a seventy-eight-year old male wrote, "It's confusing because I've never seen a psychologist." These comments suggest that many older adults do not view services in a personally relevant manner. Thus, while they may have generally positive attitudes about mental health services, they have not considered what these services would entail for them.

## External Barriers

Transportation, cost, knowledge of insurance, as well as enrollment in Medicare and enrollment in a supplemental insurance plan were considered as individual factors. Knowledge of the coverage of mental health services by an individual's insurance policy was a significant predictor of utilization for both the Baby Boomers and older adult group. In addition, having Medicare significantly predicted the older adult group's responses to what they would do if they experienced depressive symptoms.

### Transportation and Cost

As predicted, neither transportation nor cost predicted utilization. These findings may partially reflect the socioeconomic and functional status of this sample. Most individuals in the older cohort group (74%) reported that they would be able to drive themselves to seek services. In addition, the majority of the sample was married, which indicates that even older participants were likely to have the assistance of a partner in providing transportation. Finally, the sample represents a socioeconomic group that may have access to funds to help pay for services and if necessary, to pay for transportation. Thus, cost and transportation would be less likely to hamper this sample's seeking services than would be true for a less functional or lower SES sample.

Despite the fact that these factors were predictive of utilization, it should be noted that the cost of mental health care was discussed by several Baby Boomer participants in the open-ended question. For example, a 40-year-old woman stated, "I am appalled at how expensive therapy is, even with insurance. I can't afford the $35 per week it would cost me, so I have to rely on my Prozac instead." A 46-year-old woman discussed her daughter and her family seeking therapy and commented on how helpful this had been, but that she feels "sadly, cost is often a deterrent to their going." These comments reflect that while cost may not be a barrier to seeking treatment, it may interfere with individuals get the type or length of treatment they desire.

## Medicare

Medicare enrollment was negatively related to older adults' responses regarding who they felt would be most effective in treating depressive symptoms. Consistent with the fact that Medicare was not predictive of past or future likelihood of utilization, Mickus (2000) found that despite explaining to participants over the age of 65 that Medicare only covers 50% of outpatient mental health services, the majority of the sample reported they would be open to seeking these services. It is again important to note the differences in findings for future likelihood of utilization and the situational measures of future utilization. When asked the overall likelihood of their seeking future services, older adults reported a likelihood equal to that of the Baby Boomers. But, when given a specific situation to respond to, older adults reported less likelihood in seeking help first from a mental health provider or believing a mental health provider would be effective. Thus, it is possible that participants in the Mickus and colleagues study would

have reported the Medicare policy as a barrier if a more specific situation was described or if they were actually attempting to address a mental health concern.

### Supplemental Insurance

The majority of the sample reported having supplemental insurance plans, making this factor impossible to test as a barrier to utilization. The fact that almost all individuals could afford supplemental insurance is consistent with cost not being a barrier to seeking mental health services for this sample. The findings from recent literature suggest that by being able to afford supplemental insurance this sample faces quite different challenges in terms of accessing care than would a sample which could not afford supplemental health care. Data have shown that those with supplemental insurance plans are more likely to make at least one physician visit per year (Mentnech, Ross, Park, & Brenner, 1995) and more likely to receive preventive services (Blustein, 1995), less likely to delay their care because of costs and more likely to medical care from a primary care doctor rather than in a hospital (Landerman et al., 1998). Thus, this barrier must continue to be explored in terms of its impact on mental health service utilization.

### Knowledge of Insurance

Knowledge of insurance coverage of mental health services predicted utilization for the Baby Boomers and older cohort group. Since past utilization of services was controlled for, these findings cannot simply be explained by the fact that when individuals use mental health services they are likely to become familiar with their insurance policies in regards to these services. Secondly, the findings remained significant when education was included in later analyses, suggesting these findings are also not solely a product of the socioeconomic status on utilization as discussed above.

The importance of insurance knowledge should be considered with respect to the recent study by Mickus, Colenda and Hogan (2000). They found that while the majority of adults age 50-65 report knowing their insurance policy's coverage of mental health services, many individuals are inaccurate in their understanding of how services are covered. For example, although most insurance plans do not equally cover the costs of mental health and medical services, 43% of the sample reported that they believed the coverage was equal. Thus, while participants' knowing their insurance policy predicts utilization, it is important to learn if the expectations for treatment coverage are accurate.

Given the relationship between knowledge of insurance and utilization, it appears essential for mental health providers to increase awareness about insurance coverage and insure that individuals who desire services are accurate in their knowledge of their insurance plan. In addition, by providing this information, individuals may be more satisfied with their services if they are prepared for how their insurance will cover the treatment they desire.

## Internal Barriers

Treatment fears, beliefs regarding memory controllability, aging concerns, self-concealment, attitudes towards psychotherapy and depressive symptoms were considered as possible predictors of service utilization. Treatment fears, beliefs regarding memory controllability and attitudes towards psychotherapy predicted utilization for both cohort groups. Self-concealment and depressive symptoms predicted utilization for the Baby Boomers. In addition, differences in treatment fears and memory controllability were found between depressed and non-depressed individuals.

The treatment fears found to be significant in the present study were, interestingly, different from those found for younger populations. In the study by Deane and Chamberlain (1994), when all four treatment fearfulness scales were tested simultaneously in a college student sample, stigma concerns and image concerns predicted future likelihood of utilization. In contrast here, when all subscales of treatment fearfulness were tested simultaneously, therapist responsiveness and coercion concerns were significant predictors of utilization for middle aged and older adults.

The relevant concerns regarding treatment for each age group may be partially related to the stages of identity development as described by Erik Erikson (1963). In his model, younger individuals are thought to be in a stage of struggling to define who they are (identity versus identity diffusion) and thus it is logical that the college aged sample would be most concerned about how mental health treatment would change or reflect on how they define themselves. In contrast, middle aged and older adults are more likely to have a solid sense of their own identity and a stable personality (Costa & McCrae, 1988) and may not perceive mental health treatment as a threat to their self definitions. Thus, coercion concerns are relevant to this age group as these concerns would relate to a therapist convincing an individual to go against that which feels most comfortable to them.

It is also interesting to consider that contrary to hypotheses, therapist responsiveness positively predicted utilization. Here, the approach-avoidance theory is applicable (Kushner & Sher, 1989). Consideration of therapist responsiveness would be relevant when one is actively considering choosing a therapist. It is then that one may

begin to consider how different therapists available will respond to concerns. In contrast, coercion concerns may be present as a part of a more general sense of skepticism for mental health providers and may occur prior to an individual actively considering the utilization of services. Thus, therapist responsiveness may represent approaching the services available, while coercion concerns may be associated with avoidance of psychological services in general.

Therapist responsiveness and coercions concerns, both concerns related directly to the service provider predicted utilization. This finding is consistent with the results of other studies in which older adults report that they are open to psychological services, but would prefer to receive them from their primary care provider (Arean et al., 2002). Older adults' hesitation in seeking mental health treatment may be associated with their trust in the provider of these services, rather than with services themselves. This finding has led some researchers to suggest more involvement from physicians in early stages of treatment for older adults (Arean et al., 2002). Although direct involvement of the physician may or may not be necessary, these findings confirm the importance of physicians providing both assurance and increased referrals for mental health services for their older patients. In the open-ended question, several participants discussed the importance of their doctor's opinion. An eighty-year-old female participant stated, "I would first check with my family doctor about emotional problems. If he advised seeing a psychologist, then I would be willing to seek help."

### Memory Controllability and Aging Concerns

Memory controllability and aging concerns individually predicted utilization for the Baby Boomers. It is interesting to consider how, specifically, beliefs in the utility of

effort in maintaining memory are related to beliefs regarding the effort required for psychotherapy. Indeed, those who are willing to believe that a mental health provider could be effective are likely to believe that in general, effort is useful in changing how one thinks and feels about him or herself. It may be that these individuals believe in a flexibility of self and in self-improvement in self and thus are apt to believe in the ability to change all aspects of who they are, including their memory and cognitive ability.

Memory controllability and aging concerns did not individually predict utilization for older adults. However, contrary to predictions, beliefs of inevitable decline were positively related to participants believing that a mental health provider would be most effective in treating depressive symptoms. These findings are surprising given that one would assume a belief in inevitable decline would be related to beliefs that psychotherapy could not be useful. A recent study (Chumbler, Cody, & Beck, 2001) found that those older adults with cognitive impairment, but no functional impairment, were less likely to seek services than those with both cognitive and functional impairment. Thus, older adults may not view psychological services as useful unless their day-to-day functioning is impaired. Those who assume that their memory will decline may have identified the symptoms of depression as related to the functional decline they expect with inevitable age-related cognitive decline. Thus, cognitive impairment alone may be related to older adults avoiding services; beliefs that it may affect their functioning may actually increase their openness to mental health services.

## Self-Concealment

The results for self-concealment should be interpreted with caution. Given that self-concealment involves a lack of revealing one's true feelings and hiding experiences

associated with shame, it may be that those who are more likely to self-conceal did not give an accurate report of their past or future likelihood of utilization. However, for the Baby Boomers, self-concealment positively predicted seeking help first from a mental health provider for depressive symptoms. Given Baby Boomers' knowledge of mental health services, these individuals may be familiar with the confidentiality requirements of mental health providers and may feel safer turning to a mental health provider if they became depressed than they would in turning to those in their social network or a medical doctor. In addition, as has been suggested in past literature, self-concealment has been found to be positively related to service utilization in those who are distressed (Cramer, 1999). Thus, the small, but significant relationship found here may be explained by those individuals who were experiencing distress within the Baby Boomer sample.

## Attitudes Towards Psychotherapy

Consistent with past literature (Currin, Schneider, Hayslip, & Kooken, 1998; Fischer & Farina, 1995; Lasocki & Thelen, 1987; Lundervold & Young, 1992), attitudes towards psychotherapy appeared to play a crucial role in this study in the utilization of psychological services for middle aged and older adults. However, again it is interesting to note the contradiction that has been found for older adults in recent literature in which attitudes have improved but the utilization of services has not dramatically changed (Gatz & Smyer, 2001). It appears that it would be useful to have more knowledge in terms of what contributes to forming these attitudes and the differences between attitudes towards psychological services in general, and those attitudes which might occur in a specific, personally relevant situation, such as experiencing depression.

Given the high rate of recurrence of depressive symptoms (Lewinsohn, Allen, Seeley, & Gotlib, 1999), it not surprising that depressive symptoms were related to past utilization for the Baby Boomers. Those who have sought mental health services may have ongoing difficulties with depression which they are now re-experiencing.

Based on Kushner and Sher's interpretation of approach and avoidance relating to distress, it is also not surprising that despite their previous service use, depressed individuals reported less likelihood of utilizing future services due to their high level of fear and concern about receiving services. Depressed individuals also reported higher levels of treatment fears than non-depressed individuals. These fears, which could make individuals avoid treatment are also indicative of considering how treatment could help them to feel better. For the older adult group, the fact that more fears are not being reported by depressed individuals suggests that treatment may not be being considered. Thus, it may be necessary for medical and mental health care providers to help these individuals identify depressive symptoms and help them to consider options for seeking help.

The differences found between depressed individuals and non-depressed individuals in memory controllability beliefs and aging concerns is consistent with recent literature which has found that many older adults who complain of memory problems to their providers are actually experiencing depression rather than cognitive decline (Comijs, Deeg, Dik, Twisk, & Jonker, 2002; McBride & Abeles, 2000). Thus, providers should be aware of screening for depressive symptoms rather than only focusing on cognitive screening for individuals with memory complaints. This appears to be

especially true for older adults given their lack of treatment consideration as discussed above. Patients may even be referred by their medical providers for mental health treatment to address their memory concerns, which could help older adults feel more comfortable in their reasons for seeking treatment and allow them to utilize services.

## Limitations

The first major limitation of this study is its cross-sectional design. It is difficult to assess to what extent the differences found here are the product of cohort, time of testing and age. Thus, as stated above, although the barriers to mental health services differ for the Baby Boomers and older adult group, it is unclear to what extent these differences will remain as the Baby Boomers age. Under-utilization of services has been documented for a substantial amount of time, suggesting that some barriers to services may be related to aging, rather than cohort. However, with a cross-sectional study, these factors are impossible to tease apart. A longitudinal study that followed these individuals over time would be useful in learning how, for that particular cohort group barriers, attitudes and fears towards services may change.

The second potential limitation of this study was the nature of the sample. There was a lack of sufficient representation of those in ethnic minority groups as well as lower SES groups. In addition, the sample had fairly high levels of education and may possess more knowledge about mental health services than those with less education. In addition, in terms of the older adult group, the sample was made up mainly of high functioning older adults. In order to complete the questionnaires, the participants' cognitive functioning had to be relatively intact. In addition, the majority of the individuals were functioning independently. Thus, this sample was not representative of the more frail or

lower functioning older adult population. These barriers are specific to this population and further research is required to assess the extent to which they can be generalized.

The third limitation to the study may have been the yes/no and Likert scale response format used for the majority of the questionnaires. The use of supplemental open-ended questions helped to address this issue to a certain extent, but many participants indicated that the response they wanted to give was not included on a section of the questionnaire. For example, many participants reported additional options for which they would go to first or feel would be most effective for depressive symptoms. It may be useful for future studies to include more open-ended questions in which participants could share their views on mental health services.

Finally, the fact that a mental health provider conducted this research may have had an impact on the results. This may have been especially true for the older adult group, who as described earlier may be more hesitant to share their doubts or skepticism about a health provider, due to viewing this provider as an authority figure or feeling that this is not polite behavior. The results may have been quite different if the questionnaire was given by a media agency or consumer reporting group, in which the participants are not concerned about the impact their responses may have directly on the individuals conducting the research.

## Conclusions and Future Directions

This study's aim was to identify barriers to service utilization for older adults and attempt to provide information that can be useful in mental health clinical practice, administration and policy. Both research and clinical applications of the findings may be useful in providing better mental health services to older adults.

In terms of demographic barriers, the study's results continue to support the notion of taking into account individual, cohort and group differences when identifying barriers to mental health care and utilization. Thus, the current health care system may be able to meet the demands of this group, while the system may be under-prepared to address the needs of the aging Baby Boomers. In addition, gender, SES and religiosity were found to impact utilization and future utilization studies should attempt to begin to identify how the barriers to mental health service utilization differ for men and women, for poorer individuals and for religious groups. In addition, given that past literature has suggested that mental health services are poorly utilized by minority groups, future research should be focused on finding ways to recruit members of these groups to discuss their experiences with mental health care services. While recruiting older adults from minority groups has been found to be difficult, much information could be gained even from a small sample in which individuals could describe their views. In addition, the changing demographics of older adults in this country indicate that minority representation should increase in the older population in the next decade. Thus, it may be easier to gain access to a more diverse group as these changes in the population occur.

In terms of external barriers to mental health care utilization, health care insurance appears to be a major factor in the utilization of services. It is not sufficient to label cost a barrier to utilization, as this does not appear to reflect the true nature of the problem. Instead, efforts should be made to continue to address the coverage policies of insurance companies. It will be useful for mental health care providers to become involved with research efforts to demonstrate the difficulty of achieving successful treatment outcomes with a lack of sufficient insurance coverage for their patients. In

addition, mental health providers should study how mental health treatment may help to reduce other health care costs for patients by teaching them strategies to cope and address physical limitations. Finally, the importance of knowledge regarding insurance policies appears to be a beneficial area for mental health research. Many older adults may be unaware that any coverage of mental health services is provided by their health care insurance or may assume that their insurance covers more of mental health services than it actually does. Thus, they may be more likely to utilize these services if information is provided on how the coverage applies.

In terms of internal barriers, although attitudes towards psychotherapy appear to be the most consistent, internal predictor of past and future utilization for both groups, treatment fearfulness and memory controllability do appear to be useful factors to include in mental health service utilization research. Future studies should test specific models which relate these factors to utilization, attitudes, and levels of distress. In addition, it is interesting to consider how increased treatment fears in therapist responsiveness are related to a higher likelihood of service utilization for older adults. Further information could be gained by assessing how older adults think of services when they are exposed to mental health services and providers in medical settings and asked more specific questions about what situations they believe mental health providers may be useful in. It appears that they may benefit from hearing about the specifics of what treatment may entail so that they can begin to imagine themselves in therapy situations and find ways it could be useful. This may also help them to identify the concerns they have about therapy which discourage them from using mental health treatment.

In general, it is interesting to consider the pattern of responses seen here for older

adults in terms of their willingness to report their hesitations regarding mental health services. It seems that including a general measure of future utilization as well as situational, specific format was useful in eliciting older adults' likelihood of using psychotherapy. Thus, future studies could provide older adults with specific descriptions or videos of simulated therapy sessions which would allow them to expose to themselves and to the researcher their concerns and hesitations regarding therapy. In addition, it would be interesting to re-administer the Treatment Fearfulness scale with depression symptoms described and then have participants complete the questionnaire.

In addition to providing more specific, situational information for older adults to approach their concerns regarding therapy, it appeared useful to have included open-ended questions as a portion of the study. This suggests that it would be interesting to ask older adults in a more open-ended format about their views and concerns regarding mental health services, as well as having them describe the situations in which they have been exposed to mental health services. This format could provide more in-depth information on their beliefs. In addition, the utility of this format was also useful for the middle-aged adults. It is extremely important, given the continued need to gather information on barriers to service, for participants to be able to guide researchers and clinicians by describing their individual experiences with the mental health care system.

# APPENDIX

## QUESTIONNAIRES ADMINISTERED

# ADULT HEALTH SERVICES STUDY
## University of Massachusetts at Amherst

**Karyn Skultety and Susan Whitbourne, Ph.D.**

Please complete the enclosed questionnaire. Try to find a quiet place to work without interruption. There are nine sections in the questionnaire. Complete all nine sections and try to answer each item, leaving no items blank. Questions may be skipped if they make you uncomfortable. If an item or section seems confusing or requires clarification, please re-read the directions for that section and respond as you interpret the question. There will be a section at the end of the questionnaire in which you may indicate those areas that you found confusing. Please be as open as possible- there are no right or wrong answers to any questions. Be sure to check over your responses after you have finished to make sure that there are no blank items or skipped pages. When you have completed the packet, please seal it in the envelope provided and place the enclosed sticker over the flap. If you have questions, feel free to contact Karyn Skultety at (413)-545-0041 (e-mail:karyns@psych.umass.edu) or Susan Whitbourne at (413)-545-4306 (e-mail:swhitbo@psych.umass.edu).

We appreciate your cooperation in completing this packet. Your responses will help provide important information about the use of health and mental health services in adulthood.

## INFORMED CONSENT FOR VOLUNTEERS

This is an optional extra-credit project for an introductory psychology course at the University of Massachusetts at Amherst. Taking part in research is an integral part of being a psychology major, pursuing a graduate degree in psychology, and eventually, becoming a psychologist. Students are being asked to administer to a relative or friend 40 years of age or older a packet of questionnaires concerning the use of health and mental health services in adulthood.

Please complete the enclosed questionnaire in a quiet place to work without interruption as best you can. If an item or section seems confusing or requires clarification, please re-read the directions for that section and respond as you interpret the question. Try not to hesitate but give your first response- your honest answer is appreciated.

All responses to the questionnaire will be kept confidential and anonymous. The student who administered this questionnaire will not have access to any of your responses. In addition, this consent form will be removed in order to remove your name from the response packet.

To insure your confidentiality: Place the questionnaire in the envelope provided, place the sticker provided across the seal and return your packet to the student, who will bring the packet to the experimenters. Packets not sealed with this sticker cannot be accepted. If you are uncomfortable with any questions or any part of this procedure, you are free to skip those questions or sections or withdraw your consent and discontinue your participation at any time without penalty.

If you have any questions regarding your participation in this project, or any section of this questionnaire, please contact Karyn Skultety at (413)-545-0041 (e-mail: karyns@psych.umass.edu) or Susan Whitbourne at (413)-545-4306 (e-mail:swhitbo@psych.umass.edu).

This research will help us to understand the use of health and mental health services in the adult years and we very much appreciate your assistance. Thank you for your cooperation!

_____ _____

Participant signature (relative or friend of student) Date

Karyn Skultety, Department of Psychology, Division IV,
University of Massachusetts at Amherst, (413)-545-0041

Susan Whitbourne, Ph.D., Professor of Psychology,
University of Massachusetts at Amherst (413)-545-4306

ID Code #_____

**SECTION ONE**

1. Date of Birth _____/_____/_____
Month / Day / Year

2. Gender: Female_____ Male_____

Please check **one** answer for each of the following questions:

3. Current Marital Status: Single_____ Married_____ Cohabitating_____
Separated_____ Divorced _____ Widowed_____

4. Ethnicity: Caucasian _____ African-American _____ Hispanic_____
Asian _____ Other (specify)_____

5. Current Living Situation: Own home _____ Rent apartment_____
Home of children_____ Retirement Community_____ Other (specify)_____

6. How many years of education have you completed? _____
(High School Grad = 12, College Grad = 16 or more, Grad School = 17 or more)

7. What, if any, is your religious affiliation?_____

8. How many times a year do you attend religious services?_____

9. How religious would you say you are? Very_____ Somewhat_____ Not at all____

10. Are you retired? Yes_____ No_____

11. Most recent occupation (If retired, most recent occupation prior to retirement):

_____

12. Please describe your current physical health and any medical conditions:

_____

_____

## SECTION TWO

1) Have you ever sought the services of a general physician? YES NO

If yes, how many times have you seen a general physician in the past year?____

2) Have you ever sought the services of a psychologist? YES NO

If yes, how many times have you seen a psychologist in the past year? ____

3) Have you ever sought the services of a psychiatrist? YES NO

If yes, how many times have you seen a psychiatrist in the past year? ____

4) Have you ever sought the services of a social worker? YES NO

If yes, how many times have you seen a social worker in the past year? ____

5) Have you ever sought the services of an internist? YES NO

If yes, how many times have you seen an internist in the past year? ____

6) Have you ever sought the services of a dentist? YES NO

If yes, how many times have you seen a dentist in the past year? ____

7) Have you ever sought the counseling services of your priest or minister? YES NO

If yes, how many times have you seen a priest or minister in the past year? ____

## SECTION THREE

1) Are you currently enrolled in Medicare? YES NO

2) Are you currently enrolled in Medicaid? YES NO

3) Do you have additional health insurance other than Medicare or Medicaid? YES NO

4) Do you know your insurance company's reimbursement policy for psychological services? YES NO

5) Are you satisfied with your insurance company's reimbursement policy for psychological services? YES NO DON'T KNOW

6) Does cost prevent you from seeking health or mental health services? YES NO

7) How would you get to a provider if you were seeking health or mental health services?

a) Drive myself

b) Have a family member or spouse drive me

c) Take public transportation

d) Take a taxicab

e) Walk

f) Other

7) Does a lack of transportation prevent you from seeking health or mental health services? YES NO

**SECTION FOUR**

Imagine that you had decided to see a professional psychologist or counselor for a personal problem. Read each statement carefully and circle the number that indicates how concerned you would be with the statement according to the following scale:

1. Not Concerned
2. Slightly Concerned
3. Moderately Concerned
4. Very Concerned
5. Extremely Concerned

1. Whether therapy is what I need to help me with my problem. 1 2 3 4 5
2. Whether I will be treated as a person in therapy. 1 2 3 4 5
3. Whether the therapist will be honest with me. 1 2 3 4 5
4. Whether the therapist will take my problem seriously. 1 2 3 4 5
5. Whether the therapist will share my values. 1 2 3 4 5

6. Whether everything I say in therapy will be kept confidential. 1 2 3 4 5

7. Whether the therapist will think I'm a bad person if I talk about everything that I have been thinking and feeling. 1 2 3 4 5

8. Whether the therapist will understand my problem. 1 2 3 4 5

9. Whether my friends will think I'm abnormal for coming 1 2 3 4 5

10. Whether the therapist will think I'm more disturbed than I am. 1 2 3 4 5

11. Whether the therapist will find out things I don't want him or her to know about me and my life. 1 2 3 4 5

12. Whether I will learn things about myself that I don't really want to know. 1 2 3 4 5

13. Whether I'll lose control of my emotions while in therapy. 1 2 3 4 5

14. Whether the therapist will be competent to address my problem. 1 2 3 4 5

15. Whether I will be pressured to do things in therapy I don't want to do. 1 2 3 4 5

16. Whether I will be pressured to make lifestyle changes that I feel unwilling or unable to make right now. 1 2 3 4 5

17. Whether I will be pressured into talking about things that I don't want to. 1 2 3 4 5

18. Whether I will end up changing the way I think or feel about things and the world in general. 1 2 3 4 5

19. The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general. 1 2 3 4 5

20. Whether seeking treatment would affect (or would have affected) my job or job prospects if an employer found out about it. 1 2 3 4 5

21. Whether an employer will question (or would have questioned) my ability if he/she knows I'm attending therapy. 1 2 3 4 5

22. Whether attending therapy will create a psychiatric label that might stay with me. 1 2 3 4 5

23. Whether friends and family will see my future behavior as being attributable to my having had psychological therapy. 1 2 3 4 5

24. Whether some people will like or respect me less if I say I am receiving psychological treatment. 1 2 3 4 5

25. Whether people treat me differently if they know I have been receiving therapy. 1 2 3 4 5

26. Whether people will think me weak because I can't solve my own problems. 1 2 3 4 5

27. Whether I will lose my friends from seeing a therapist. 1 2 3 4 5

28. Whether being in therapy will affect my relationship with those closest to me (partner, family, close friends). 1 2 3 4 5

29. Whether those closest to me (partner, family, close friends) will think less of me for seeing a therapist. 1 2 3 4 5

30. Whether those closest to me will feel guilty as a result of my seeking therapy. 1 2 3 4 5

If you did have a personal problem, how likely is it that you would seek help from a psychologist or counselor? Circle a number from 1 to 9 below that best describes the likelihood:

| Extremely Unlikely | | | Neutral | | | | | Extremely Likely |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

## SECTION FIVE

This is a questionnaire about your memory. Please indicate the extent to which you agree or disagree with each statement. Provide the answer that is right for you by circling the number from 1 to 7 that best describes your beliefs. If you **strongly disagree** with the statement, you would circle the number **1**. If you **strongly agree** with the statement, you would circle the number **7**. If you are **neutral**, you would circle the number **4**.

1. There's not much I can do to keep my memory from going downhill. 1 2 3 4 5 6 7

2. I can remember the things I need to. 1 2 3 4 5 6 7

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. I can't seem to figure out what to do to help me remember things. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. No matter how much I use my memory, it is bound to get worse as I get older. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Alzheimer's disease is a common problem among the elderly. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. As I get older, I'll need to rely on others to remember things for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. If I work at it, I can improve my memory. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. I'm not good at remembering things. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. If I use my memory a lot, it will stay in shape, just like muscles do if I exercise. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. I can find ways to improve my memory. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. When I forget something I am apt to think I have Alzheimer's disease. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. I can't remember things, even if I want to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. I think there's a good chance I will get Alzheimer's disease. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. If I use my memory often I won't lose it. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. As I get older, I won't have to rely on others to remember things for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. If I really want to remember something I can. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. I can think of strategies to help me keep up my memory. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. If I want to have a good memory I need to have others to help me remember. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. I sometimes think I have Alzheimer's Disease. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

20. When it comes to memory, there is no way I can make up for the losses that come with age. 1 2 3 4 5 6 7

**SECTION SIX**

| | | |
|---|---|---|
| 1) Are you basically satisfied with your life? | YES | NO |
| 2) Have you dropped many of your activities and interests? | YES | NO |
| 3) Do you feel that your life is empty? | YES | NO |
| 4) Do you often get bored? | YES | NO |
| 5) Are you in good spirits most of the time? | YES | NO |
| 6) Are you afraid that something bad is going to happen to you? | YES | NO |
| 7) Do you feel happy most of the time? | YES | NO |
| 8) Do you often feel helpless? | YES | NO |
| 9) Do you prefer to stay at home, rather than going out and doing new things? | YES | NO |
| 10) Do you feel you have more problems with memory than most? | YES | NO |
| 11) Do you think it is wonderful to be alive now? | YES | NO |
| 12) Do you feel pretty worthless the way you are now? | YES | NO |
| 13) Do you feel full of energy? | YES | NO |
| 14) Do you feel that your situation is hopeless? | YES | NO |
| 15) Do you think that most people are better off than you are? | YES | NO |

## SECTION SEVEN

Please read each of the following statements carefully and circle the number that indicates your level of agreement.

1. Strongly Disagree
2. Disagree
3. Neither Agree or Disagree
4. Agree
5. Strongly Agree

| | | | | | |
|---|---|---|---|---|---|
| 1. I have an important secret that I haven't shared with anyone. | 1 | 2 | 3 | 4 | 5 |
| 2. If I share all my secrets with my friends, they'd like me less. | 1 | 2 | 3 | 4 | 5 |
| 3. There are lots of things about me that I keep to myself. | 1 | 2 | 3 | 4 | 5 |
| 4. When something bad happens to me, I tend to keep it to myself. | 1 | 2 | 3 | 4 | 5 |
| 5. I'm often afraid that I'll reveal something I don't want to. | 1 | 2 | 3 | 4 | 5 |
| 6. Telling a secret often backfires and I wish I hadn't told it. | 1 | 2 | 3 | 4 | 5 |
| 7. I have a secret that is so private I would lie if anybody asked me about it. | 1 | 2 | 3 | 4 | 5 |
| 8. Some of my secrets really torment me. | 1 | 2 | 3 | 4 | 5 |
| 9. My secrets are too embarrassing to share with others. | 1 | 2 | 3 | 4 | 5 |
| 10.I have negative thoughts about myself that I never share with anyone. | 1 | 2 | 3 | 4 | 5 |

## SECTION EIGHT

**1) If in the future, you ever felt so sad, discouraged, lacking in satisfaction, guilty, or irritated that you couldn't snap out of it:**

What would you do about it?
a) Keep it to yourself
b) Tell a family member or friend
c) Tell a health professional

Who would you go to first for help?
a) General Physician
b) Psychologist
c) Psychiatrist
d) Social Worker
e) Internist

Who would be most effective in treating these problems?
a) General Physician
b) Psychologist
c) Psychiatrist
d) Social Worker
e) Internist

**2) If in the future, you felt so dizzy, confused, or had trouble with your memory or balance that it really bothered you:**

What would you do about it?
a) Keep it to yourself
b) Tell a family member or friend
c) Tell a health professional

Who would you go to first for help?
a) General Physician
b) Psychologist
c) Psychiatrist
d) Social Worker
e) Internist

Who would be most effective in treating these problems?
a) General Physician
b) Psychologist
c) Psychiatrist
d) Social Worker
e) Internist

**3) If in the future, you felt pain or numbness in your jaw or left arm, had shortness of breath when exerting yourself, or felt pressure on your chest:**

What would you do about it?
1) Keep it to yourself
2) Tell a family member or friend
3) Tell a health professional

## SECTION NINE

Below are a number of statements pertaining to psychology and mental health issues. Please read each of the following statements carefully and circle the number that indicates your level of agreement.

1. Disagree
2. Partly Disagree
3. Partly Agree
4. Agree

| | | | | |
|---|---|---|---|---|
| 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention. | 1 | 2 | 3 | 4 |
| 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. | 1 | 2 | 3 | 4 |
| 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. | 1 | 2 | 3 | 4 |
| 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help. | 1 | 2 | 3 | 4 |
| 5. I would want to get psychological help if I were worried or upset for a long period of time. | 1 | 2 | 3 | 4 |
| 6. I might want to have psychological counseling in the future. | 1 | 2 | 3 | 4 |
| 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help. | 1 | 2 | 3 | 4 |
| 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. | 1 | 2 | 3 | 4 |
| 9. A person should work out his or her own problems; getting psychological counseling would be a last resort. | 1 | 2 | 3 | 4 |
| 10. Personal and emotional troubles, like many things, tend to work out by themselves. | 1 | 2 | 3 | 4 |

**IF YOU FEEL IT WOULD BE HELPFUL, PLEASE ANSWER THE FOLLOWING OPTIONAL QUESTIONS:**

**Indicate any question or section which you felt needed clarification. Tell us what made it confusing and how you decided to answer the question.**

_____

_____

_____

_____

_____

**Share your thoughts on psychotherapy and/or mental health services. Feel free to share your opinions, thoughts and feelings as well as any personal experiences you feel are relevant (and are comfortable sharing). Also, feel free to expand on any of the items asked in the nine sections of the questionnaire. Any information will be helpful!**

_____

_____

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(Continue on the back of the page if you need more room)

## DEBRIEFING FORM

You have just completed a packet of questionnaires regarding the use of health and mental health services. The variables being investigated in this study are the history of health and mental health service utilization and barriers to seeking services including depression, attitudes regarding psychotherapy, treatment fearfulness, dementia fearfulness, and help-seeking attitudes. The goal of the study is to learn more about how services are utilized and to discover what barriers are preventing the utilization of mental health services. Ideally, your responses will help to psychologists to better serve you! Thank you very much for taking your time to complete all nine sections of the questionnaire.

The anticipated date of completion for this study is May, 2002. If you are interested in the results and would like written information at the time of its completion, please contact Karyn Skultety at (413)-545-0041 (e-mail:karyns@psych.umass.edu) or Susan Whitbourne at (413)-545-4306 (e-mail: swhitbo@psych.umass.edu). We will be happy to make the results of this study available. After all, we couldn't have done it without you!

Thank you again!

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University of Massachusetts at Amherst (413)-545-4306

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