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# Age Group Differences in Older Adults' Attitudes Toward Psychotherapy and Willingness to Seek Help

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AGE GROUP DIFFERENCES IN OLDER ADULTS' ATTITUDES TOWARD  
PSYCHOTHERAPY AND WILLINGNESS TO SEEK HELP

A Dissertation

Submitted to the School of Graduate Studies and Research

In Partial Fulfillment of the

Requirements for the Degree

Doctor of Psychology

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Older adults have been found to underutilize mental health services. Limited research has focused on older adults' attitudes toward psychotherapy. Eighty-six older adults participated in this study, which investigated age group differences (e.g., young old versus older old) in older adults' attitudes toward psychotherapy and willingness to seek help. The effect of previous experience with psychotherapy on attitudes and willingness to seek help was also examined. Results indicated that younger groups were more likely to hold positive attitudes toward psychotherapy, and were more willing to seek services. Younger groups of adults were also more likely to have had a previous experience with mental health treatment, and prior experience with psychotherapy was found to have a positive effect on attitudes. Younger groups were more willing than older groups to seek psychotherapy services when barriers to treatment (e.g., transportation and financial barriers) were removed.

## TABLE OF CONTENTS

Chapter	Page
One	AGE GROUP DIFFERENCES IN OLDER ADULTS’ ATTITUDES TOWARD PSYCHOTHERAPY AND WILLINGNESS TO SEEK HELP.....1  Barriers to Treatment.....3 Mental Health Attitudes.....6 Purpose of Study.....20
Two	METHOD.....23  Participants.....23 Measures.....26 Procedure.....28
Three	RESULTS.....30  Hypothesis 1.....31 Hypothesis 2.....35 Hypothesis 3.....38 Hypothesis 4.....43 Exploratory Findings.....44
Four	DISCUSSION.....47  Findings.....47 Limitations and Future Directions.....55 Conclusion.....59  REFERENCES.....61  APPENDICES.....65  Appendix A – Questions Adapted from OAK-MHS (Lundervold & Young, 1992).....65 Appendix B – Questions Adapted from WSHQ (Cohen, 1999).....68 Appendix C – Additional Questions.....70 Appendix D – Demographic Questions.....71 Appendix E – Senior Center Survey.....72 Appendix F – Informed Consent Letter.....83

## LIST OF TABLES

Table	Page
1 Demographic Characteristics of Participants.....	24
2 Mean Scores and Standard Deviations for OAK-MHS and WSHQ for YY, YO, and OO.....	32
3 Scheffe Post-Hoc Tests for OAK-MHS and WSHQ.....	34
4 Age Groups and Previous Experience with Psychotherapy.....	36
5 Logistic Regression Analysis for Previous Experience with Psychotherapy – OO as Reference Group.....	37
6 Logistic Regression Analysis for Previous Experience with Psychotherapy – YO as Reference Group.....	38
7 Age Groups and Help Seeking - Transportation Barrier Removed.....	39
8 Logistic Regression Analysis for Willingness to Seek Psychotherapy Transportation Barrier Removed.....	40
9 Age Groups and Help Seeking - Financial Barriers Removed.....	41
10 Logistic Regression Analysis for Willingness to Seek Psychotherapy - Financial Barriers Removed.....	43
11 Multivariate Tests – Wilks’ Lambda.....	45
12 Tests of Between-Subjects Effects.....	45

## LIST OF FIGURES

Figure		Page
1	Histogram displaying frequency of age of participants in sample.....	25
2	Scatterplot of OAK-MHS and WSHQ scores for each participant, color-coded by age group.....	33

CHAPTER ONE  
AGE GROUP DIFFERENCES IN OLDER ADULTS' ATTITUDES TOWARD  
PSYCHOTHERAPY AND WILLINGNESS TO SEEK HELP

The population of older adults (ages 60 and older) has grown at a rapid rate over the past three decades. It is estimated that one out of every eight Americans is an older adult (Kinoshita, Sorocco, & Gallagher-Thompson, 2005). Kinoshita, Sorocco, & Gallagher-Thompson assert that the population of older persons in the United States is projected to double by the year 2030; totaling 71.5 million older persons in this country. This statistic suggests that the present cohort of middle-aged adults, or “baby boomers” will likely make much greater demands on the mental health system than the present cohort of older adults. Although there is no evidence for a causal relationship between growing older and developing psychological disorders, it is clear that older adults do have needs for mental health services related to disorders such as depression, anxiety, adjustment issues, and cognitive impairment (Robb, Haley, Becker, Polivka, & Chwa, 2003). Older adults commonly struggle with depression, which is not considered to be a part of “normal aging.” High rates of depression are often related to significant losses that are experienced by many older adults during this time of life, including bereavement and “role loss” (Kinoshita, Sorocco, & Gallagher-Thompson). Older adults may experience stress resulting from loss of independence and adjustment to a new and different living situation. Furthermore, medical conditions and physical illnesses in older adulthood may prevent individuals from engaging in enjoyable activities, including social activities. Older adults may also struggle with anxiety disorders such as generalized anxiety disorder and posttraumatic stress disorder.

In proportion to their numbers and mental health needs, the older adult population has been found to underutilize mental health services. While they represent approximately 12% of

the population, they receive only 2% of private psychiatrists' time and approximately 4 to 7% of community mental health services, making them one of the most underserved groups in the mental health system (Hatfield, 1999). In fact, the disparity between need and service utilization increases with age such that age is inversely predictive of seeking services for mental health related issues (Currin, Hayslip, Schneider, & Kooken, 1998). Studies suggest that service use is even lower among ethnic minority older adults as compared to ethnic minority younger adults, and ethnic minority older adults are much more likely to seek services for mental-health related problems through a primary care physician rather than a mental health professional (Kinoshita, Surocco, & Gallagher-Thompson, 2005).

One outcome of this lack of contact with the mental health system is that mental illness in older adults is often undiagnosed or untreated (Woodward & Pachana, 2009). Not only do untreated mental disorders contribute to a possibly lower quality of life for the older adult, but they may also exacerbate caregiving stress and the burden on informal caregivers of older adults (Choi & Gonzalez, 2005). Beyond its profound impact on quality of life for the older adult and caregiver(s), mental illness in older adults is also a risk factor for functional disability, and may even predict premature mortality (Sarkisian, Lee-Henderson, & Mangione, 2003). The costs of under-treatment of mental illness in older adults are great, both to the individual and to society as a whole.

Low service utilization among older adults has sparked research aimed to provide explanations for the neglect of mental health needs among older adults. Much of this research has focused on barriers to treatment, and more specifically, the barriers to treatment that may be especially pronounced in an older adult population, which may help to explain underutilization in this group. Some research has focused on older adults' own attitudes toward psychotherapy and

the persistence of stigma attached to mental illness in an older adult population. Older adults' attitudes toward psychotherapy will be explored as a possible contributing factor to low service utilization. The following sections will provide an overview of the literature related to the barriers to treatment that exist in an older adult population, and also older adults' attitudes toward psychotherapy and willingness to seek help for a mental health related problem. Literature related to older adults' own personal experience with psychotherapy will also be reviewed. Lastly, older adults will be examined as a heterogeneous group, with emphasis on the differences that exist between the "young old" and the "older old".

### Barriers to Treatment

Several studies have examined possible explanations for underutilization of mental health services in the older adult population. Research suggests that a variety of barriers, both real and perceived, may play a role in underutilization of mental health services among older adults (Currin, Hayslip, Schneider, & Kooken, 1998). There may be problems with affordability, transportation, convenience, and information about available resources (Woodward & Pachana, 2009). It is possible that difficulties with transportation, and the inconvenience that results from lack of access to transportation, could deter many older adults from seeking services for mental health related problems.

One of the greatest barriers to serving older adults with mental illness is the way in which mental health services are funded (Hatfield, 1999; Lebowitz, 1993). Financial considerations often determine the type of care, if any, that an older individual receives. Many older persons with low income who do not qualify for Medicaid are currently unable to pay for needed outpatient psychotherapy services. Financial issues may also deter many mental healthcare professionals from seeing elderly clients, as older persons have traditionally been viewed as

unappealing clients due to their difficulty in paying and the low Medicare-allowable fee (Shapiro, 1986).

Mental health professionals themselves may present a significant barrier to treatment in the older adult population. Many professionals may be reluctant to pursue training in psychotherapy for older adults and therefore, may be more reluctant to accept older adult clients (Lasoski, 1986). Reluctance among clinicians to work with older adults could be the result of long-standing pessimism regarding the effectiveness of psychotherapy with older adult clients, perhaps beginning with Freud's assertion in 1905 that "old people are no longer educable" (Kuruville, Fenwick, Haque, & Vassilas, 2006). Additionally, resistance to working with older adults may be based on a number of assumptions, including the assumption that older persons have irreparable symptoms and are often reluctant to change (Lasoski, 1986). Other contributing factors to reluctance to working with older adults may include anxiety in the therapist surrounding issues of death and dying, and a perceived "low status" among mental health professionals that may be attached to work with older adult clients (Goodstein, 1982). According to Goodstein (1982), some therapists may hold the attitude that investment in therapy for persons who do not have many years of life remaining is simply not worth the effort.

Although there may be widespread pessimism about doing therapy with older adults, this pessimism is not supported by research evidence. For instance, Scogin and McElreath (1994) found effect sizes for the treatment of depression in older adults to be comparable to those found for the treatment of depression in younger individuals. Psychotherapy is an important treatment option because older persons generally have increased sensitivity to all medications and their side effects, including anti-depressant medication (Kinoshita, Surocco, & Gallagher-Thompson, 2005). Additionally, older adults often suffer from physical disorders that complicate or

contraindicate pharmacotherapy, making psychotherapy an important treatment option (Mintz, Steuer, & Jarvik, 1981). It is likely that the negative stereotyping of older adults in our society and the societal stigma that is attached to aging has contributed to inadequate mental health treatment for an older adult population (Hatfield, 1999). Consequently, many researchers point to a shortage of geriatric mental health professionals as a major barrier to treatment (e.g., Currin, Hayslip, Schneider, & Kooken, 1998; Woodward & Pachana, 2009).

In addition to the negative stigma that is often attached to older adults and aging in our society, depression and anxiety are commonly viewed as a “normal” part of aging (Kinoshita, Surocco, & Gallagher-Thompson, 2005). Such societal attitudes toward older adults may help to explain why many older persons are often not referred to treatment by family members or friends. Believing that symptoms of depression are the “expected response” to growing older may act as a strong barrier to care seeking for many older persons with depression (Sarkisian, Lee-Henderson, & Mangione, 2003). According to Sarkisian et al. (2003), attributing mental health problems to old age rather than actual illness is a common phenomenon. These researchers found that attributing general health problems to old age has been shown to increase the risk of early mortality, yet the causal mechanism for this relationship is unknown. Sarkisian et al. (2003) hypothesized that attributing depression to old age may prevent older adults from seeking care when they feel depressed. The authors reported that those who attributed depression to aging had a four times greater likelihood of believing that it is not very important to discuss feelings of depression with a professional, as compared to those who attributed depression to a mental illness.

It is suggested that among older persons with depression, attributing feelings of depression to old age may be an important barrier to seeking care, which highlights the

importance of older adults themselves as a significant barrier to treatment. Older adults' attributions and attitudes toward mental illness may be important to consider when investigating potential barriers to treatment. The exploration of older adults' attitudes toward mental illness may help to provide some explanation for low service utilization among this group. Therefore, literature related to older adults' attitudes toward psychotherapy and willingness to seek help is investigated in the following section.

### Mental Health Attitudes

Perhaps one of the most significant barriers to treatment of older adults with mental illness is their own attitude toward seeking services. Reasons why older adults have been thought to resist mental health services include lack of education regarding mental health and also generational negative attitudes and stigma attached to mental illness (Robb, Haley, Becker, Polivka, & Chwa, 2003). Farberman (1997) conducted a study to investigate public attitudes and knowledge about psychologists and mental health care. Such research indicates that the public has very little understanding about the qualifications and credentials of mental health providers and cannot discriminate one mental health provider from another. Additionally, Gill (2008) investigated the persistence of stigma and discrimination surrounding mental illness that exists in the general population and found that outrageous stereotypes of persons with serious mental illness remain widespread.

It has been suggested that lack of knowledge regarding mental health services and the persistence of stigma attached to mental illness is even more pronounced in a geriatric population (Robb et al., 2003). In other words, the proposed stigma that is attached to seeking services for mental health-related issues in the general population may be especially strong among older adults. Older adults in our society were raised during a time when the misconceptions and

stigma surrounding mental illness were even greater than they are today (Hatfield, 1999). The thought of having a mental disorder may generate embarrassment and shame in this population as compared to younger generations. Older adults may fear being “institutionalized,” and they may be unaware that most mental health problems can now be treated successfully in the community.

Negative attitudes toward seeking mental health services may stem from a time in our society’s history when mental illness was viewed as socially unacceptable and unmentionable, or interpreted as a personal failure or spiritual deficiency (Woodward & Pachana, 2009). Negative attitudes and fear are thought to be significant contributors to treatment avoidance. It has also been suggested that older people are reluctant to use mental health services because they may no longer feel capable or worthy of being helped (Lasoski & Thelen, 1987). They may wish to avoid financial consequences and perceived disdain resulting from accepting public aid. Furthermore, older adults may perceive available services as inappropriate, unnecessary, or as a threat to their independence. Negative attitudes and beliefs about mental illness in older adults may lead to underreporting and misdiagnosis of mental health problems in this population (Quinn, Laidlaw, & Murray, 2009). Despite these suggestions of negative attitudes toward seeking mental health services among older adults, little empirical evidence exists to either support or refute the presence or effects of such attitudes, and research that does exist has been conflicting.

In one early study in the area of older adults’ attitudes toward mental illness and seeking mental health services, Waxman, Carner, and Klein (1984) found that “healthy” older adults had a poor opinion of mental health professionals, and preferred to seek services from a primary care physician. In this particular study, 88 older adults sampled from a largely African American,

urban, low-income population were interviewed about their help seeking behaviors for psychological problems. Results of the study indicated that older adults had low mental health service utilization in the past and little intention for mental health service utilization in the future, even if psychological distress was encountered. These results were some of the first to suggest that ageism and societal stigma may actually present less of a barrier to mental health service utilization than older adults' own attitudes and biases toward mental health professionals and psychiatric services. However, questions were raised about the composition of the sample in the study and whether the results actually suggest more about cultural and racial differences than age differences (Lundervold & Young, 1992).

Lundervold and Young (1992) also presented some of the first empirical data on older adults' attitudes and knowledge regarding mental health services. Fifty older adults recruited from an ongoing study of the health of older adults took part in this study. Participants were mostly Caucasian (98%) with a median income and mean education level of \$15,000-19,999 and 12.4 years respectively. Older adults in the sample were given the Older Adults' Attitudes and Knowledge toward Mental Health Services Scale (OAK-MHS), designed to assess several areas affecting older adults' use of psychological services. These domains included knowledge of aging and mental health, cost/knowledge of payment mechanisms, access/availability of services, stigma, effectiveness of treatment, religiosity, and openness to discussion. Results of the study indicated that older adults have moderately negative attitudes and knowledge deficits with regard to mental health services. The highest negative attitudes/knowledge deficits were in the areas of knowledge of mental health and aging, religiosity, and stigma. Lundervold and Young also began efforts to establish the psychometric properties of the OAK-MHS scale, designed to assess these variables in older adults.

In a study examining attitudes toward mental health services in Korean-American older adults, Jang, Chiriboga, and Okazaki (2009) found that negative attitudes toward mental health services were observed among those who believed that depression is a sign of personal weakness and that having a mentally ill family member brings shame to the whole family. On the other hand, the belief that depression is a medical condition was found to be a predictor of positive attitudes toward mental health services. Culture-influenced beliefs were shown to have a substantial contribution to attitudes toward mental health services in both younger and older adults. However, results of this study suggested that older adults are not only more subject to cultural misconceptions and stigma related to mental disorders, but also their attitudes toward service use are negatively influenced by this stigma.

Segal, Coolidge, Mincic, & O'Riley (2005) suggest that stigma attached to mental illness does exist in an older adult population, and it does, in fact, relate to a reluctance to ask for professional help for mental health related issues. In this particular study, the older adult group, comprised of almost exclusively Caucasian, community-dwelling individuals (mean age = 75.1), was compared to a group of younger adults enrolled in an undergraduate institution (mean age = 20.6). The authors found that as compared to younger adults, older adults perceived the mentally ill as more lacking in social skills. Older age groups were more likely to view those with mental illness as more embarrassing and more undesirable. Despite evidence of negative attitudes toward mental illness, results of the study conducted by Segal et al. indicate no differences in self-reported willingness to seek help, with willingness levels quite high for both younger and older age groups. However, analysis showed that increased negative attitudes toward mental illness (e.g., the view that the mentally ill have poor interpersonal skills) were associated with decreases in willingness to seek psychological services. Therefore, this study

lends additional support to the notion that negative attitudes toward mental illness among older adults may be an important barrier to treatment in this population.

Although help seeking from mental health professionals may be low among older adults, clergy may actually be an important source for counseling and guidance in the older adult population (Pickard & Guo, 2008). Pickard and Guo assert that older adults tend to seek help for emotional problems from clergy members at greater rates than they do from other sources including psychologists, social workers, and professional counselors. Help seeking from clergy is a common phenomenon, and Pickard and Guo focused exclusively on older adults' help seeking patterns from clergy members. The authors also examined variables that were hypothesized to be related to help seeking from clergy, including religious affiliation, religiosity, social support, and attendance at religious services. According to the study conducted by Pickard and Guo, in a sample of 317 respondents over the age of 65, a total of 34 (10.7%) of the study participants reported that they had sought help for a problem in their life from a religious leader in the past six months.

Results of the study by Pickard and Guo (2008) indicated that social support was negatively correlated with older adults' help seeking from clergy such that the less social support one has, the more likely one is to have sought help from a religious leader. In addition, attendance at religious services was positively associated with help seeking from clergy. Although this study did not compare help seeking from clergy among an older adult population to that of a younger adult population, the results do suggest that clergy may be an important source of help for older adults. Furthermore, seeking help from clergy rather than a mental health professional may actually remove some of the aforementioned barriers to treatment, and may simply be more convenient for the older adult. For example, by seeking help from a

religious leader, an older adult who regularly attends church services would have no need to locate a mental health professional, arrange transportation, fill out paperwork, or negotiate fees. It can also be hypothesized that help seeking from a religious leader may be associated with a lesser degree of stigma in an older adult population than help seeking from a mental health professional.

Despite a considerable amount of research suggesting that older adults hold negative attitudes toward mental health services, a growing body of research suggests that there is a reason for optimism about the receptiveness of older adults to professional mental health services (Robb et al., 2003). Robb and colleagues (2003) conducted a study using a sample of relatively affluent, and highly educated older adults living in a Florida retirement community. Results indicated that despite the fact that younger adults appeared to utilize mental health services to a greater extent, experience with mental health services among older adults was not uncommon, and overall, the older adults in the sample reported being highly satisfied with their experience. However, older adults reported being less confident about their knowledge of mental health care and appropriate treatment as compared to their younger counterparts. Older adults did express a desire to learn more about mental health issues and services. Results of the study are encouraging and suggest that older adults, particularly more affluent and highly educated older adults, might be more receptive to mental health services, despite lower utilization of these services. Although the results of this specific study were consistent with previous literature suggesting that older adults have less experience, less knowledge, and lower likelihood of seeking help for most mental health issues, the findings indicate that some groups of older adults may value access to this care, such that attitudes did not appear to be overwhelming barriers to providing needed mental health services to this particular older adult population.

The expectation that attitudes among older adults toward psychotherapy would grow increasingly positive has gained empirical support. Currin, Hayslip, Schneider, & Kooken (1998) were among the first to investigate change across cohorts in attitudes toward mental health services. The authors hypothesize that although many of the oldest groups of older adults may have misconceptions about the mental health system, the younger/late-born cohorts of older adults will have a more accurate understanding. Furthermore, the authors contend that this will bring greater acceptance of mental health care, reflecting a historical shift toward greater psychological-mindedness among older persons. The study conducted by Currin et al. (1998) compared data regarding mental health attitudes collected in 1977 from a sample of older adults to data collected in 1991 from a subsequent, later-born cohort of older persons. As compared to the 1977 cohort, the 1991 cohort was more highly educated, rated their overall health as better, had higher annual incomes, and were more likely to have utilized mental health services in the past. In general, the authors hypothesized that cohort differences would influence mental health attitudes. Specifically, later-born cohorts of older adults were hypothesized to have more positive mental health biases than earlier-born cohorts. Furthermore, later-born cohorts were predicted to be more open to the possibility of seeking mental health services than earlier-born cohorts. Later-born cohorts were also thought to have greater knowledge of the range of problems addressed by mental health professionals and also a greater breadth of conceptions of the causes of mental illness as compared to earlier-born cohorts.

Currin et al. (1998) collected data from two independent samples of community-residing older adults. The earlier-born cohort was sampled in 1977 ( $N= 91$ ; mean age = 69.9) and the later-born cohort was sampled in 1991 ( $N= 116$ ; mean age = 71.9). As compared to the 1977 cohort of older adults, the 1991 cohort had significantly higher levels of education, rated their

overall health better, and was more likely to have utilized mental health services in the past. A questionnaire packet completed by individuals in each independent sample, assessed the following domains: (1) openness to seeking psychological help, (2) professional and mental health biases, (3) range of problems helped by psychologists, and (4) breadth of conceptions of causes of mental illness.

Openness to seeking psychological help was assessed through a list of 24 problems such as deep depression, forgetfulness, and arguments with children. Participants were asked whether they would seek help from a therapist or counselor for each of these problems. Professional and mental health biases were measured by a five-point Likert scale describing a variety of negative attitudes that one might hold with respect to mental health care issues. Agreement with such statements indicated a negative attitude toward the value of mental health care, and the stigma attached to seeking psychological services. Additionally, the domain of range of problems helped by psychologists was assessed by asking participants in each group to respond to a list of problems designed to measure their estimate of the range of experiential difficulties that mental health professionals might help to remedy, such as death of a spouse, loneliness or isolation, and sexual difficulties. The domain of breadth of conceptions of causes of mental illness was defined by a 10-point Likert scale assessing agreement or disagreement with a variety of reasons why one might develop mental health problems. Finally, to assess previous use of mental health services, participants were asked whether they had ever sought professional help for an emotional or mental problem of a personal nature, to which they responded by checking “yes” or “no.”

Analyses conducted by Currin and colleagues (1998) clearly suggest that attitudes among older adults toward psychotherapy services have changed as a function of the cohort group to

which they belong. Later-born cohorts demonstrated more positive attitudes as compared to earlier-born cohorts of older adults. Specifically, results indicated a significant difference in breadth of conception of causes of mental illness, or the tendency to conceive of mental health problems in a rigid and stereotypical fashion versus seeing such problems in a broader, more flexible manner. Moreover, results suggested that the later-born cohort was more flexible in thinking about mental illness and subscribed less stereotypical etiological explanations of mental health problems as compared to those of the earlier-born cohort. Furthermore, results indicated that later-born cohorts had a more inclusive estimate of the range of problems addressed by mental health professionals. According to Currin et al. (1998), these data suggest that the deficits about knowledge regarding aging and mental health and older adults' negative expectations about the effectiveness of treatment have decreased among later-born cohorts of older adults. Additionally, with respect to openness to seeking psychological help, members of the later-born cohort were more willing to seek services for a greater variety of psychological issues as compared to the earlier-born cohort group.

When controlling for level of education, self-reported health, and income, significant cohort differences in attitudes remained (Currin et al., 1998). Based on the results of this study, the conclusion is drawn that later-born cohorts of older adults had more positive attitudes toward mental health and psychological services than earlier-born cohorts of older adults. The study suggests that attitudes toward seeking services for mental health related issues are likely to be influenced by historical and cultural forces. For example, later-born cohorts may have increased exposure to psychological information in the media, or they may have increased awareness of the modern mental health movement via local mental health associations and health organizations. Scientific and technological advances that have taken place since the 1950s including advances

in electronic media, print, and transportation may have affected the cohorts differently.

Furthermore, the trend toward deinstitutionalization in the field of mental health may have provided later-born cohorts with a greater awareness of outpatient mental health treatment. A product of this mental health movement and deinstitutionalization has been the establishment of Community Mental Health Centers, which have been thought to have a major impact in meeting the mental health needs of older adults throughout the country. Such influences may have had a greater impact on later-born cohorts of older adults, who may have benefited from Community Mental Health Centers to a greater extent than earlier-born cohorts.

A recent study conducted by Woodward and Pachana (2009) contends that negative attitudes claimed by previous research to exist among older adults may not be as pervasive as previously assumed. Results indicated that stigmatization was not an important barrier to treatment. Furthermore, results suggested that there were “no significant effects” of older age on attitudes toward seeking mental health services. Despite this assertion, the authors point out that some attitudes do in fact differ between age groups. Specifically, older adults were less likely to have previously utilized mental health services and they were less confident regarding their knowledge of mental health care. Furthermore, Woodward and Pachana found that older adults were found to be less likely to seek help for “less severe” and more common problems including depression, anxiety, divorce, bereavement, and stress, and they were more likely to seek services from a general medical practitioner for mental health related problems. However, the authors noted that older adults in the sample indicated that access to mental health care was “very important,” and they would seek help for “more severe” problems such as schizophrenia and suicidal feelings.

Research conducted by Woodward and Pachana lends support to the notion of a “positive cohort shift” in attitudes toward mental health services among older people, such that attitudes may differ as a function of the cohort group to which an individual belongs. However, a significant limitation of this study was that persons as young as 50-years old were included in this particular sample, suggesting that the sample may be comprised mostly of late middle-aged adults rather than older adults (mean age = 63.5). Consequently, the results presented may not provide an accurate reflection of *older* adults’ attitudes toward seeking psychotherapy services.

Given the complexities of attitudinal research with an older adult population, and taking into account the possibility of a positive cohort shift in older adults’ attitudes toward seeking mental health services, a study conducted by Quinn and colleagues (2009) aimed to explore older adults’ attitudes toward mental illness in the context of attitudes toward aging, experience, and health-related outcomes. Quinn et al. hypothesized that negative attitudes toward mental illness would be associated with negative attitudes toward aging, and furthermore, would be mediated by personal experience. Clinical participants were recruited with the assistance of clinicians from the Area Clinical Psychology Service and the Area Old Age Psychiatry Service of the United Kingdom. Non-clinical participants were sampled with assistance of the local branch of Age Concern and the Elderly Forum of the United Kingdom. This particular study used several measures to assess attitudes toward mental illness in a clinical and non-clinical older adult population. Subscales of the Barriers to Mental Health Services Scale (BMHSS) relating to ageism and stigma were used to evaluate negative attitudes toward mental illness. The Understandability Questionnaire was used to assess attitudinal statements toward depression later in life. For example, the measure was designed to reflect the conceptualization that “It is natural to be depressed in late life because there are good reasons for it, therefore, there is no point in

treatment.” Items were rated on a seven-point Likert scale, and higher scores were indicative of a greater belief that depression is a normal consequence of the aging process. Furthermore, participants in the study were given the Attitudes Toward Aging Questionnaire and the Rame Questionnaire, designed to measure internalized ageism in an older adult population. Lastly, general health and well-being was assessed using the General Health Questionnaire and the Reported Health Behaviors Checklist.

Results obtained by Quinn et al. (2009) indicated that older participants in the sample endorsed a range of positive and negative attitudes toward mental illness. However, when such attitudes were examined in the context of attitudes toward aging, a more complex pattern of results emerged. Negative attitudes toward mental illness were associated with negative attitudes toward aging in the entire sample. Furthermore, clinical participants, or those with a prior experience with mental health services, reported more positive attitudes toward mental illness than non-clinical participants. Results of the study suggested that attitudes toward mental illness and aging may be linked and mediated by personal experience and capacity for psychological self-regulation when faced with age-associated adversity. The authors do acknowledge that the question remains unanswered as to whether having negative attitudes actually causes older people to seek less care for mental health related issues. Additionally, because the non-clinical group was significantly older than the clinical group, the study cannot preclude the possibility that attitudinal differences were the result of cohort effects. The authors state a number of concerns related to their findings, including the potential failure in older adults to recognize symptoms of mental illness, and the disinclination to seek professional help for treatable mental health related conditions. Furthermore, the study highlights the importance of understanding

older adult clients in terms of cohort factors and within a broader context of aging, because such factors have the potential to influence the therapeutic process and therapeutic outcome.

Kuruvilla, Fenwick, Haque, and Vassilas (2006) aimed to explore attitudes of older adults with depression toward different types of treatment for depression. Participants were recruited from an inpatient facility in the United Kingdom. The authors found that older adults with depression view psychotherapy to be just as effective and acceptable a treatment for depression as antidepressant medications, but far less likely to cause side effects. The findings indicated that older patients with depression viewed psychotherapy as an effective, safe, and acceptable form of treatment. However, each of the adults included in this particular sample was currently receiving mental health services, and had also received these services in the past. The fact that this sample had experience with psychotherapy begs the question: can the positive attitudes observed in this particular study be explained by personal experience with psychotherapy?

Although generational effects and cohort differences in attitudes toward seeking mental health services have been previously examined in the literature, little emphasis has been placed on the differences that exist among various cohorts of older adults at the same period in time. Literature on aging has begun to distinguish between two distinct groups of older adults: the Young Old (YO) and the Older Old or Oldest Old (OO) (e.g., Matt & Dean, 1993). Several authors have asserted that in order to understand the future of an aging population, we must first distinguish between the YO and the OO, and recognize the many differences between these two unique groups (Baltes & Smith, 2003).

Older adults are an exceptionally diverse group, and we can distinguish between different groups of older adults because their needs, abilities, and lifestyles are so different (Ables & APA, 1997). As compared to the YO, there is evidence that the OO often experience sizeable losses in

functioning. In particular, aspects of emotion and wellbeing including life satisfaction, positive affect, aging satisfaction, and loneliness show significant negative changes in the OO. Perhaps the most notable shift in the mental health status of the OO is the dramatic increase in the prevalence of dementia in this age group as compared to the YO. Plassman et al. (2007) found that the prevalence of dementia increased with age, from approximately 5% in the youngest groups of older adults to approximately 37.4 % in those aged 90 and older. Other studies show prevalence rates for dementia as high as 62 % in 95-year olds and 88 % in those 100 years and over (e.g., Blansjaar, Thomassen, & Van Schaick, 2000).

In general, sizeable losses are encountered as individuals reach the oldest ages. Approximately 24 % of individuals over the age of 85 reside in nursing homes, but only 6 % of those aged 75-85 and only 1.4 % of those aged 65-75 do (Ables & APA, 1997). In addition to significant differences in physical and mental functioning between the YO and the OO, these two groups may represent different cohorts with different generational influences. According to Baltes and Smith (2003), old age has two distinct faces. However, these age groups are almost always combined in studies of older adults. As a consequence, the significant differences between these two ages groups are often lost in most studies of older adults examining those aged 65 and older.

Different studies offer different operational definitions of the YO and the OO. Baltes and Smith (2003) suggest a population-based definition of the YO and the OO. According to these authors, the transition between young old and oldest old can be thought of as being the chronological age at which 50% of the birth cohort is no longer alive. This definition would put the transition from the YO to the OO in developed countries at approximately 75 years of age. For the purposes of this study, the YO group will be defined as those ages 65 to 74, and the OO

group will be defined as those ages 75 and older. In light of the significant differences that have been found to exist between the YO and the OO, the current study will examine age group differences (YO vs. OO) among older adults in attitudes toward mental health services.

### Purpose of Study

The study of cohort differences conducted by Currin and colleagues (1998) provides the empirical basis for the hypothesis that attitudes toward mental health services among older adults will continue to change in a positive direction across future cohorts. Research suggests that there has been improvement in attitudes toward mental health services in older adults, but statistics still show low service utilization, generally negative attitudes, and the persistence of stigma attached to mental illness. The study by Currin et al. (1998) is one of the only that examines cohort differences in older adults' attitudes toward mental health services, and it is over a decade old. Furthermore, studying different cohorts of older adults at different historical time periods raises the question of whether the attitudinal differences that were found, and attributed to cohort effects, could actually be attributed to time of measurement effects instead. This represents an important confound in the Currin et al. study, which was addressed in this present study. In addition, one must question whether a study utilizing different measures of attitude would yield such significant differences. Such questions were further investigated in the current study of cohort differences in older adults' attitudes toward psychotherapy services. Quinn et al. (2009) suggest that attitudes toward seeking mental health services may be mediated by personal experience with such services. Therefore, the current study examined personal experience with psychotherapy as an additional factor that could potentially have an effect on attitudes toward mental health services in different cohorts of older adults.

In proportion to their numbers and mental health needs, older adults have been found to underutilize mental health services (e.g., Robb et al., 2003, Woodward & Pachana, 2009). Research has attempted to provide explanations for low service utilization in this population, focusing on barriers to treatment and mental health attitudes held by older adults, but it is apparent that more research is needed in this area. The purpose of the current study is to investigate age group differences (YO vs. OO) in older adults' attitudes toward receiving psychotherapy services. Age group differences among older adults in general have not been extensively researched, and there is no empirical research that examines age groups differences (YO vs. OO) in attitudes toward mental health services among older adults. Therefore, this study will examine cohort differences that exist among older adults at the same period in time regarding attitudes toward mental health services, allowing for an investigation of generational influences on attitudes.

The stigma attached to mental illness and the perceived societal stigma attached to seeking services for a mental health related problem will be examined in each of these unique groups of older adults. Older adults' knowledge about mental health and mental health services will be investigated. Knowledge about mental health services is considered to be important, as past research has indicated that older adults feel less confident in their knowledge of mental health and mental health services (Robb et al., 2003). Lack of knowledge about mental health services may be low, even if attitudes toward seeking services are relatively positive. Willingness to seek psychological services will also be investigated in the YO and the OO. Based on previous literature examining cohort differences in attitudes toward mental health services, it is hypothesized that the YO group of older adults will have more positive attitudes and a greater willingness to seek psychological services as compared to the OO group of older

adults (Hypothesis 1). Hypothesis 1 is based on the suggestion of a “positive cohort shift” in attitudes toward mental health services in older adults (Currin et al., 1998). If this positive cohort shift exists, it should be evident when comparing these two distinct groups of older adults.

Quinn et al. (2009) suggest that attitudes toward seeking mental health services in an older adult population may be mediated by a personal experience with psychological services. Kuruvilla, Fenwick, Haque, and Vassilas (2006) also lend support to the notion that personal experience with psychotherapy might actually mediate attitudes toward mental health services in their study of older adults currently seeking treatment for depression. Therefore, based on the literature, it is hypothesized that previous experience with mental health services would have a positive effect on the dependent variable, such that older adults’ attitudes toward mental health services will be increasingly positive when there has been a prior personal experience with psychological services (Hypothesis 2).

It is hypothesized that younger groups of older adults will report a greater willingness to receive psychotherapy services when barriers to treatment are nonexistent (Hypothesis 3). When barriers such as transportation and affordability are thought to be removed, or are perceived to be absent, the youngest groups of older adult will have a greater reported willingness to seek mental health services as compared to older groups of adults. Lastly, it is also hypothesized that the oldest group of older adults will report greater willingness to seek help from a clergy member (Hypothesis 4).

## CHAPTER TWO

### METHOD

#### Participants

Participants were recruited through Aging Services senior centers in rural and suburban areas of western Pennsylvania, including Indiana and Armstrong counties of Pennsylvania. Ninety individuals volunteered to participate in the study; however, four of these participants were not included in the study as they were under the age of 60. Individuals excluded from the study were aged 55, 54, 44, and 42, and these individuals were volunteers at the senior centers and were not thought to be representative of the true population of older adults served by the senior centers. Therefore, responses from these individuals under the age of 60 were excluded from the study. As a result, a total of 86 participants aged 60 and older were included in this study. Due to the fact that individuals under the age of 65 completed surveys at various senior centers, comparisons were made with three levels of age, with a younger-young old (YY) group included in the analyses. This YY group was thought to be important, as it represents a group of up-and-coming older adults who will be entering retirement in the near future. Thus, age of participants was divided into three distinct groups: YY = ages 60-64 ( $n = 16$ ), YO = ages 65-74 ( $n = 31$ ), OO = ages 75+ ( $n = 39$ ). The mean age of this sample was 73.9 ( $SD = 9.3$ ), with ages ranging from 60 to 96. There were 12 participants over the age of 85. A total of 21 males and 65 females participated in the study, and the vast majority of participants identified as Caucasian/White. Table 1 shows demographic characteristics of the sample. Additionally, Figure 1 shows the frequency of each age in this particular sample.

Table 1

*Demographic Characteristics of Participants (N = 86)*

Demographic Variable	Age Group			Total
	60-64	65-74	75+	
<b>Gender</b>				
Male	6	7	8	21
Female	10	24	31	65
<b>Education</b>				
Grade School	0	1	3	4
Some High School	0	3	3	6
High School Graduate	7	15	23	45
Vocational or Technical School	3	0	1	4
Some College	2	6	5	13
College Graduate	3	1	0	4
Graduate or Professional School	1	4	2	7
No Answer	0	1	2	3
<b>Marital Status</b>				
Married	8	13	7	28
Divorced	1	3	1	5
Separated	1	0	1	5
Single/ Never married	5	3	2	10
Widowed	1	9	26	36
No Answer	0	3	2	5
<b>Living Arrangement</b>				
Living with family members	11	14	7	32
Assisted living facility	0	1	1	2
Living alone	5	13	27	45
Other	0	2	1	3
No Answer	0	1	3	4
<b>Monthly Income</b>				
\$0 - \$999	3	6	3	12
\$1,000 - \$1,999	2	2	6	11
\$2,000 - \$2,999	2	3	1	6
\$3,000+	1	0	1	2
No Answer	8	19	28	55
<b>Race</b>				
Native American/ Indian	0	0	1	1
Caucasian/ White	16	28	33	77
Other	0	1	2	3
No Answer	0	2	3	5

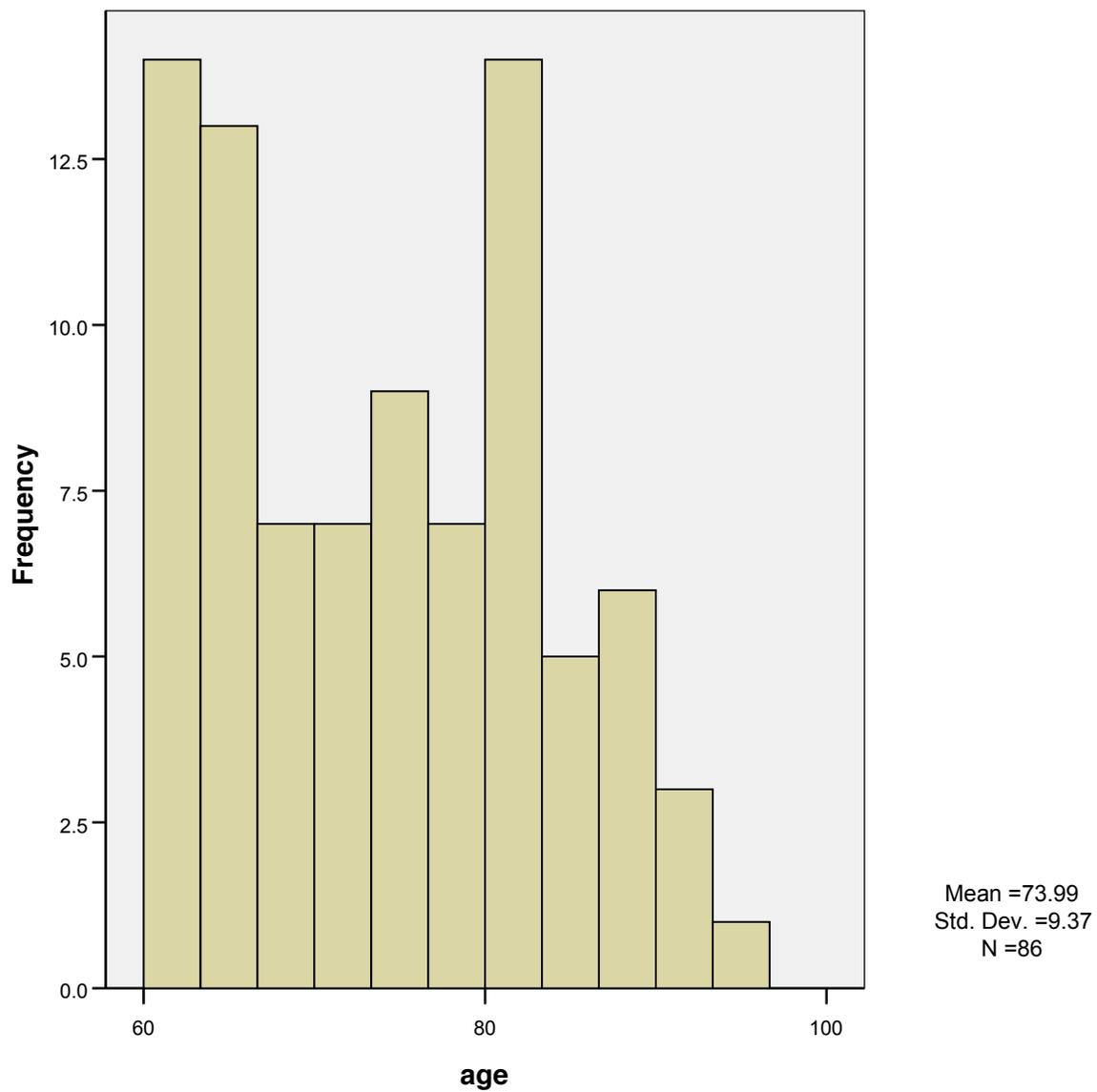


Figure 1. Histogram displaying frequency of age of participants in sample.

## Measures

Participants were administered a survey comprised of questions adapted from two measures, one of which is the Older Adults' Attitudes and Knowledge toward Mental Health Services Scale (OAK-MHS), developed by Lundervold and Young (1992) (Appendix A). The OAK-MHS is a 20-item, dichotomously scaled (yes/no) measure that was developed from an analysis of the literature on aging and psychopathology, and older adults' utilization of mental health services (Lundervold & Young, 1992). For this study, responses on the OAK-MHS were transformed from the dichotomous scale to a four-point Likert scale ranging from Strongly Agree to Strongly Disagree. This change allowed the researcher to obtain a greater range of scores, and it made OAK-MHS responses compatible with other measures that were administered. Additionally, the wording of certain items on the OAK-MHS was changed to facilitate reading with a Likert scale response format.

The OAK-MHS was designed to include items in seven areas affecting older adults' use of mental health services: (1) knowledge of aging and mental health, (2) cost/knowledge of payment mechanisms, (3) access/availability of services, (4) stigma attached to mental illness, (5) effectiveness of mental health treatment, (6) religiosity, and (7) openness to discussion. The OAK-MHS also contains one item assessing whether or not the participant has ever personally received professional mental health services (which remained dichotomously scaled). Sample items from the OAK-MHS include, "Going to see a counselor or psychologist in his or her office is embarrassing" and "When you get to be 55 years of age or older, you naturally start to feel anxious, tense, and worried." Lundervold and Young began to establish the psychometric properties of the OAK-MHS, and results indicated that the OAK-MHS was an internally consistent measure (Chronbach's coefficient alpha = .80) that may be useful in research

regarding assessment of older adults' attitudes and knowledge about seeking psychological services. Due to the fact that items on this measure have been changed, reliability and validity data on the items as formatted in the current study have not been established. The content of items, however, was not appreciably changed. Reliability was tested for the abbreviated version of the OAK-MHS and Chronbach's coefficient alpha = .705, suggesting an acceptable level of internal consistency for this adapted version of the OAK-MHS.

Questions adapted from the Willingness to Seek Help Questionnaire (WSHQ), developed by Cohen (1999), were also administered to assess older adults' self-reported willingness to seek professional services including counseling and psychological services (Appendix B). According to Cohen (1999), the WSHQ is based on a theory of the different components of the willingness to seek help that include: (1) recognition of the need for help, (2) readiness for self-disclosure, and (3) willingness to relinquish some degree of control to a helper. The questionnaire contains 33 help-seeking statements involving each of the aforementioned components of willingness to seek help as they relate to several problem areas (e.g., fears, marital conflict, sexual dysfunction, etc.). According to Cohen, the WSHQ demonstrates promising levels of reliability and validity, with a reliability coefficient (Chronbach's alpha) of .85. In the interest of survey completion time for this study of older adults, 14 items adapted from the WSHQ were administered to participants. However, due to the fact that this measure was abbreviated for this study, no reliability and validity properties could be assumed. Reliability for the abbreviated version of the WSHQ was tested and Chronbach's alpha = .741, suggesting an acceptable level of internal consistency for this shorter version of the WSHQ. Questions taken from the WSHQ reflect four problem areas: fears, grief/bereavement, physical illness/disability, and mental illness. Items that

were omitted from the WSHQ reflected problems areas that were not thought to be relevant for the purposes of this study (e.g., sexual dysfunction, marital conflict, etc.).

In addition to the OAK-MHS and items from the WSHQ, the survey administered to participants included a few additional questions assessing perceived barriers to treatment (Appendix C). For example, the participant was asked, “Is access to transportation an issue that sometimes prevents you from seeking professional services?” In addition, participants were asked, “If reliable transportation was provided, or was not a concern, would you be willing to seek professional mental health services for a problem such as depression or anxiety?” Participants were also asked, “Do financial issues sometimes prevent you from seeking professional services?” Older adults were asked, “If you knew that professional mental health services were available at little to no cost, would you consider seeking such services?” In addition to a question assessing for *personal* experience with psychotherapy, participants were asked, “Has a close family member or friend ever sought professional psychological counseling?” Lastly, the survey also contained demographic questions to determine age, gender, race, annual income, marital status, education level, and living arrangement (Appendix D). All questions/items included on the survey were printed in large font (size 16) to facilitate reading for the older adult participants. The full survey that was administered to participants in the study is found in Appendix E.

## Procedure

The primary investigator made contact with a coordinator at Aging Services in Indiana County, Pennsylvania to arrange for a date and time for the survey to be administered at each senior center. Once an agreement was made with the coordinator and the primary investigator arrived at the center, the older adults present at the senior center were informed that participation

in the study is voluntary, and that they were allowed to withdraw from the study at any point in time. They were provided with an informed consent letter (Appendix F), which did not ask for identifying information, and consent was indicated by participation. The survey was administered in pencil and paper format and participants were instructed not to put their name, or any other identifying information, anywhere on the survey. The primary investigator was present to answer any questions while participants completed the survey. The survey took approximately 15 minutes to complete, although notable variations in completion time did occur due to reading differences in the older adults. Survey completion time ranged from approximately 10 to 30 minutes.

After the primary investigator collected all surveys, participants were verbally debriefed about the purpose of the study and what was being investigated. Participants were instructed to refer to the researcher's contact information included on the informed consent letter if they wished to request any additional information about the study. Participants were then offered the opportunity to listen to a brief outreach presentation on common mental health issues in older adulthood. Individuals who did not participate in the study were still offered the opportunity to listen to the outreach presentation. Once the survey had been administered to participants at five senior centers in Indiana County, the primary investigator proceeded to make contact with an Aging Services coordinator in Armstrong County. This process continued in two senior centers in Armstrong County, Pennsylvania. The percentage of people at each senior center who agreed to participate in the study varied greatly between centers. Approximate percentages of older adults who agreed to participate in the study ranged from 40% to 90% at various senior centers.

## CHAPTER THREE

### RESULTS

Eighty-six adults aged 60 and older participated in this study, which investigated age group differences in attitudes toward psychotherapy and willingness to seek help. The study also examined prior experience with psychotherapy as an additional factor that could influence the relationship between age and attitude toward psychotherapy and willingness to seek help. Demographic data was collected during the study as part of the survey that was administered to participants. Responses for these older adults were divided into groups according to various demographic variables. Table 1 in the Methods section contains demographic characteristics of the sample. Descriptive data indicated that the mean score of the Older Adults' Attitudes and Knowledge Toward Seeking Mental Health Services Scale (OAK-MHS) for this sample was 55.4 out of a possible 78 (71.0%), with a standard deviation of 4.9. The mean OAK-MHS score found in the current study is slightly lower than the mean score of 32.5 out of 42 (77.4 %) obtained in Lundervold and Young's study. In this sample, the lowest OAK-MHS score was 40.0 while the highest was 68.0, with higher scores indicating more positive attitudes toward mental health services.

One item on the OAK-MHS asked participants if they had ever personally received psychotherapy or mental health services. A total of 26 participants (30.2%) answered "yes", indicating that they had some previous experience seeking mental health or psychotherapy services. In contrast, 60 participants (69.8%) answered "no", suggesting no personal experience with mental health treatment.

The mean score for the Willingness to Seek Help Scale (WSHQ) was 40.9 out of a possible 56 (73%) (SD = 4.2) with scores ranging from 28.0 to 53.0. Cohen (1999) obtained a

mean score of 53.14 out of a possible 75 (70.8 %), indicating a similar mean score for this abbreviated version of the WSHQ in this particular sample. Higher scores on the WSHQ indicate greater willingness to seek help. Participants were also asked about perceived barriers to seeking mental health services, including issues with transportation and finances. A total of 18 participants (20.9%) indicated that transportation issues would prevent them from seeking psychotherapy services, whereas 68 participants (79.1%) indicated that access to transportation does not present a barrier to treatment. However, a little under half of the sample (41.9%) indicated that financial issues would prevent them from seeking psychotherapy services, suggesting that the cost of services was a greater barrier to treatment in this sample.

### Hypothesis 1

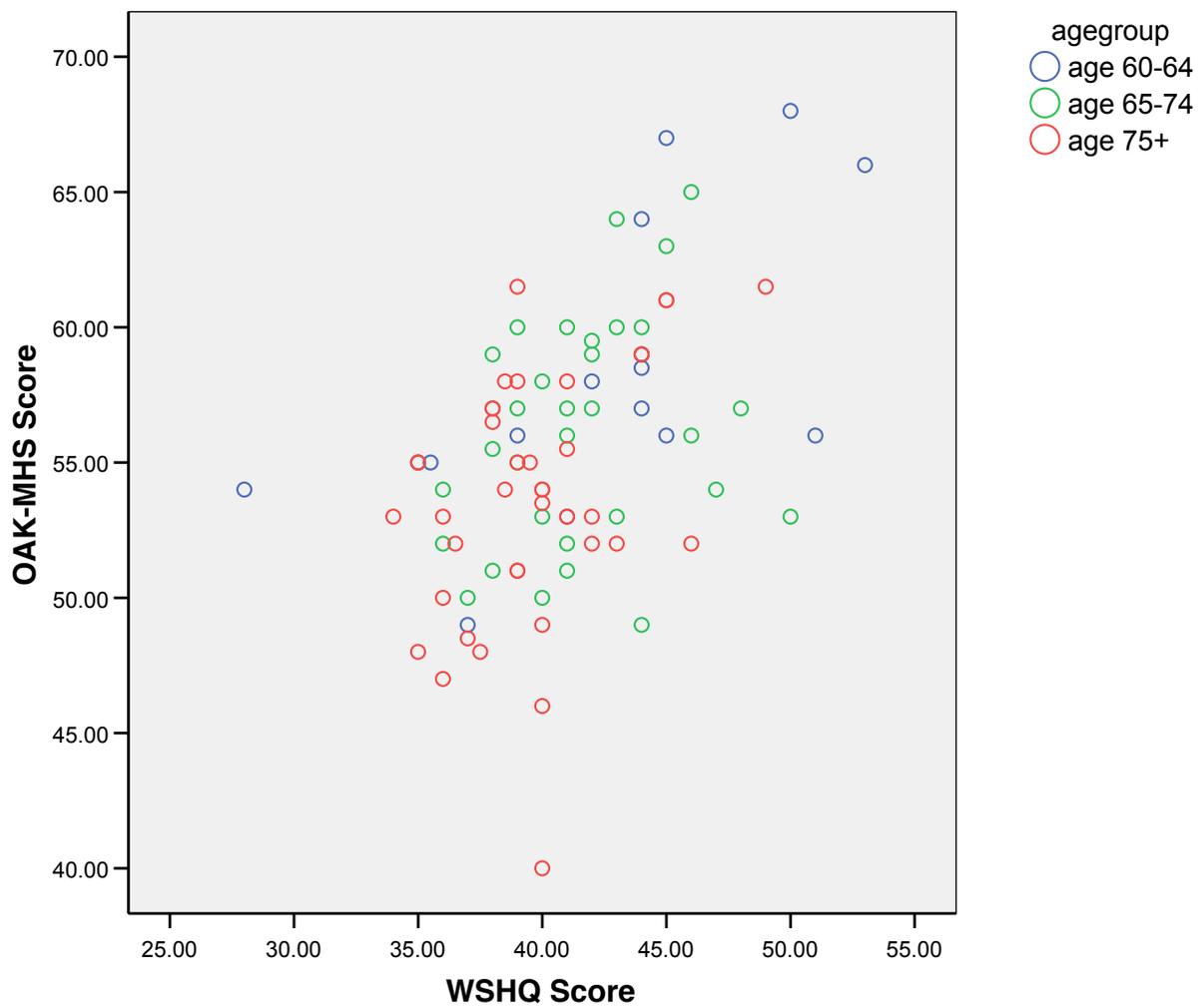
Hypothesis 1 of this study is based on the notion of a cohort shift in positive attitudes toward seeking mental health services (Currin et al., 1998). For the purpose of investigating the effect of age group on measures of attitudes toward psychotherapy and willingness to seek help a one-way multivariate analysis of variance (MANOVA) was used. Due to the fact that individuals under the age of 65 completed surveys at various senior centers, comparisons were made with three levels of age. These comparisons allowed the investigator to compare older groups of adults (over age 65) with an up-and-coming, pre-retirement group of older adults. A MANOVA examined the effect of the independent variable age (with three levels – YY, YO, and OO) on the dependent variables: total OAK-MHS scores and total WSHQ scores. It was hypothesized that attitudes toward psychotherapy would differ as a function of age, and the youngest group of adults would have more positive attitudes toward psychotherapy and greater willingness to seek help as compared to the oldest group. In other words, the YY would report more positive attitudes than the YO, and the YO would report more positive attitudes than the

OO. As predicted, there was a significant effect of age group, Wilks' Lambda = .864,  $F(4,164) = 3.122$ ,  $p = .017$ , such that younger age was associated with more positive attitudes toward psychotherapy. There was a significant main effect for age on attitudes toward mental health services,  $F(2,83) = 5.707$ ,  $p = .005$ , such that younger age was positively associated with greater OAK-MHS scores and more positive attitudes toward psychotherapy. Additionally, there were significant effects of age group on willingness to seek help,  $F(2,83) = 3.237$ ,  $p = .044$ , such that younger age was positively associated with greater willingness to seek help scores on the WSHQ. Table 2 shows the mean scores for the YY, YO, and OO groups on both the OAK-MHS and the WSHQ. Figure 2 shows a scatterplot of OAK-MHS scores and WSHQ scores for each participant according to age group.

Table 2

*Mean Scores and Standard Deviations for OAK-MHS and WSHQ for YY, YO, and OO*

Age Group	OAK-MHS	WSHQ
YY (60-64)		
Mean	58.2	42.3
N	16	16
Std. Deviation	5.4	6.4
YO (65-74)		
Mean	56.1	41.6
N	31	31
Std. Deviation	4.2	3.5
OO (75+)		
Mean	53.8	39.7
N	39	39
Std. Deviation	4.7	3.3



*Figure 2.* Scatterplot of OAK-MHS and WSHQ scores for each participant, color-coded by age group.

Scheffe post-hoc tests were used for the purpose of comparing pairwise group means. Significant age group pairwise differences were obtained for the OAK-MHS between the YY group (ages 60-64) and the OO group (age 75+). Therefore, there were significant differences in OAK-MHS scores between the YY and the OO group such that the YY group reported significantly more positive attitudes toward mental health services as compared to the OO group. Effect size was calculated and Cohen's  $d = .869$ , indicating a large effect. However, there were no significant differences in OAK-MHS scores observed between the YY and YO group, or between the YO and OO group. Table 3 shows post-hoc tests for the dependent variables of OAK-MHS scores and WSHQ scores. Despite a significant difference in the omnibus test, post-hoc tests revealed no significant difference for the effect of age group on WSHQ scores.

Table 3

*Scheffe Post-Hoc Tests for OAK-MHS and WSHQ*

Dependent Variable: OAK-MHS					95% CI	
Age group	Age group	Mean diff.	Std. Error	Sig.	Lower Bound	Upper Bound
YY (60-64)	YO (65-74)	2.089	1.432	.350	-1.480	5.659
	OO (75+)	4.449	1.381	.008	1.006	7.893
YO (65-74)	YY (60-64)	-2.089	1.432	.350	-5.659	1.480
	OO (75+)	2.359	1.119	.115	-.4309	5.150
OO (75+)	YY (60-64)	-4.449	1.381	.008	-7.893	-1.006
	YO (65-74)	-2.359	1.119	.115	-5.150	.4309
Dependent Variable: WSHQ						
YY (60-64)	YO (65-74)	.7309	1.266	.847	-2.452	3.886
	OO (75+)	2.689	1.221	.095	-.3540	5.733
YO (65-74)	YY (60-64)	-.7309	1.266	.847	-3.886	2.452
	OO (75+)	1.959	.9897	.147	-.5080	4.426
OO (75+)	YY (60-64)	-2.689	1.221	.095	-5.733	.3540
	YO (65-74)	-1.959	.9897	.147	-4.426	.5080

A total of 12 participants in the sample were over the age of 85, and it was thought that these 12 individuals might represent a distinctly different group of older adults. To ensure that the oldest participants were not responsible for the attitudinal differences observed, analyses were performed again with these 12 individuals excluded. Excluding adults over the age of 85 did not change the observed results.

### Hypothesis 2

Previous experience with psychotherapy was thought to potentially explain the observed differences in the dependent variable. Hypothesis 2 of the current study predicted that personal experience with psychotherapy would have a positive effect on attitudes toward psychotherapy and willingness to seek help, such that participants who reported a previous experience with psychotherapy would also report more positive attitudes toward mental health treatment and greater willingness to seek such services. To examine the effect of personal experience with psychotherapy on the dependent variables (OAK-MHS scores and WSHQ scores), a two-way MANOVA was used. This particular analysis was used for the purposes of explaining whether the observed differences in attitudes toward psychotherapy and willingness to seek help could be explained by age alone, or whether previous experience with psychotherapy was the factor that explained the significant differences. In other words, this analysis examined whether the differences in OAK-MHS and WSHQ scores could be explained by previous experience with psychotherapy as opposed to age group alone. Hypothesis 2 was supported and there was a significant effect of previous experience with psychotherapy, Wilks' Lambda = .906,  $F(2,79) = 4.116$ ,  $p = .020$ , such that participants who reported a previous experience with psychotherapy had higher OAK-MHS scores (more positive mental health attitudes) and higher WSHQ scores (greater willingness to seek help). When previous experience with psychotherapy was included

in the multivariate tests, the effect of age was no longer significant, Wilks' Lambda = .964,  $F(4,158) = .721$ ,  $p = .579$ . There was a significant main effect of previous experience with psychotherapy on OAK-MHS score,  $F(1,84) = 13.158$ ,  $p < .001$ , such that those with a previous experience with psychotherapy reported more positive attitudes. Effect size was calculated and Cohen's  $d = .854$ , indicating a large effect. Additionally, there was a significant effect of personal experience with psychotherapy on willingness to seek help,  $F(1,84) = 12.255$ ,  $p < .001$ , such that those with a previous experience with psychotherapy reported greater willingness to seek help. Effect size was calculated and Cohen's  $d = .739$ , indicating a fairly large effect. No significant age group by previous experience with psychotherapy interaction was found, Wilks' Lambda = .987,  $F(4,158) = .265$ ,  $p = .900$ , such that the effect of previous experience with psychotherapy on the dependent variables did not differ as a function of age group. Table 4 shows the number of participants with a previous experience with psychotherapy according to age group.

Table 4

*Age Groups and Previous Experience with Psychotherapy*

Age Group	Previous Experience with Psychotherapy	
	Yes	No
YY (age 60-64)	11 (68.8)	5 (31.2)
YO (age 65-74)	11 (35.5)	20 (64.5)
OO (age 75+)	4 (10.3)	35 (89.7)

*Note:* Percentages are reported in parentheses.

Results indicated that younger age groups of adults were more likely to have had a previous experience with psychotherapy. Logistic regression with parameter coding was used to assess the impact of age group on the likelihood that participants would report a previous experience with psychotherapy. This logistic regression procedure was used to predict whether

participants would fall into one of two groups (previous experience or no previous experience) based on their age group. The model was statistically significant,  $\chi^2(2, N = 86) = 19.413, p < .001$ , indicating that the model was able to distinguish between participants who did and did not report a previous experience with psychotherapy based on age group, such that younger groups were more likely to have had a previous experience with psychotherapy. More specifically, the YY was more likely to have had a previous experience with psychotherapy as compared to the YO group, and the YO group was more likely to have had prior mental health treatment as compared to the OO group. The model explained between 20.2 % (Cox & Snell R Square) and 28.6 % (Nagelkerke R Square) of the variance in previous experience with psychotherapy, and correctly classified 76.7 % of cases. In order to make all necessary comparisons, the logistic regression was performed twice, with both the YO and the OO as reference groups. Results of logistic regression procedure are displayed in Tables 5 and 6.

Table 5

*Logistic Regression Analysis for Previous Experience with Psychotherapy - OO as Reference Group*

Predictor	<i>B</i>	SE B	Odds Ratio
Age Group			
OO (ages 75+)			
YY (ages 60-64)	-2.958***	.755	.052
YO (ages 65-74)	-1.571*	.648	.208
Constant	2.169	.528	8.750
Chi-Square	19.413		
df	2		

*Note: \* $p < .05$ . \*\*\* $p < .001$*

Table 6

*Logistic Regression Analysis for Previous Experience with Psychotherapy – YO as Reference**Group*

Predictor	<i>B</i>	SE B	Odds Ratio
Age Group			
YO (ages 65-74)			
OO (ages 75+)	1.571*	.648	4.812
YY (ages 60-64)	-1.386*	.657	.250
Constant	.598	.375	1.818
Chi-Square		19.413	
df		2	

*Note: \*p < .05*

### Hypothesis 3

Participants were asked questions assessing their willingness to seek help if financial and transportation barriers were removed, or were nonexistent. Hypothesis 3 predicted that younger groups of older adults would report greater willingness to seek help if barriers to treatment (economic, transportation) were absent. Only 20.9% of older adults surveyed reported that problems with access to transportation would prevent them from seeking professional services. Out of this 20.9% of the total sample that indicated problems with transportation, 22.2% belong to the YY group, 27.7% belong to the YO group, and 50% are in the OO group.

When asked, “If reliable transportation was provided, or was not a concern, would you be willing to seek professional mental health services for a problem such as depression or anxiety?”, 41.9% of the total sample of older adults indicated that they would not consider seeking

psychotherapy services if transportation was provided. Additionally, a significant age group difference was observed with respect to this survey question in this sample. Out of this 41.9% of the total sample, results indicated that 18.8% of the YY group, 32.2% of the YO group, and 58.1% of the OO group stated that they would not consider seeking psychotherapy services even if transportation was provided. Table 7 shows the number of participants in each age group according to their responses on questions assessing willingness to seek help if transportation barriers were removed.

Table 7

*Age Groups and Help Seeking - Transportation Barrier Removed*

Willing to Seek Help if Transportation is Provided?	Age Group		
	YY (60-64)	YO (65-74)	OO (75+)
Yes	13 (81.2)	21 (67.7)	16 (41.0)
No	3 (18.8)	10 (32.3)	23 (59.0)

*Note:* Percentages are reported in parentheses.

Binary logistic regression was conducted to assess the effect of age group on the probability that participants would report willingness to seek psychotherapy if transportation barriers were removed. In other words, logistic regression was used to predict whether participants would fall into one of two groups (willing to seek psychotherapy or not willing to seek psychotherapy) based on age group. Using age group as a predictor variable, the model was statistically significant,  $\chi^2(2, N=86) = 9.018, p = .011$ , indicating that the model was able to distinguish between participants who answered “yes” or “no” to this question. In other words, age group was a significant predictor of whether or not participants would consider seeking mental health services if transportation barriers were removed, such that in general younger groups reported greater willingness to seek psychotherapy on this item. This is consistent the

Hypothesis 3; however, there were no differences observed between the YY and the YO group. Rather, the significant differences observed were between the YY and the OO group, and between the YO and the OO group, such that the YY and the YO groups reported greater willingness to seek therapy as compared to the OO group. The model explained between 10.1% (Cox & Snell R Square) and 13.6 % (Nagelkerke R Square) of the variance, and correctly classified 65.9% of cases. Results of this logistic regression procedure are displayed in Table 8.

Table 8

*Logistic Regression Analysis for Willingness to Seek Psychotherapy - Transportation Barrier  
Removed*

Predictor	<i>B</i>	SE B	Odds Ratio
<i>Reference Group OO</i>			
Age Group			
OO (ages 75+)			
YY (ages 60-64)	-1.785*	.720	.168
YO (ages 65-74)	-1.060*	.506	.346
<i>Reference Group YO</i>			
Age Group			
YO (ages 65-74)			
OO (ages 75+)	1.060*	.506	2.888
YY (ages 60-64)	-.724	.747	.485
Constant	.318	.329	1.375
Chi-Square		9.018	
df		2	

*Note: \*p < .05.*

Regarding financial barriers, 41.9% of the total sample indicated that economic problems prevent them from seeking professional services. Out of this 41.9% of the total sample that acknowledged economic problems as a barrier to treatment, 27.7% belong to the YY group, 38.9% belong to the YO group, and 33.3% belong to the OO group.

When asked, “If you knew that professional mental health services were available at little to no cost, would you consider seeking such services?”, a total of 36.0% of participants indicated that they would not be willing to seek mental health treatment if financial barriers were removed. Again, a significant age group difference was observed on this item. Out of this 36% of the total sample, results showed that 12.5% of the YY, 22.5% of the YO, and 56.4% of the OO would not consider seeking psychotherapy services even if the cost of services was covered. Table 9 shows the number of participants in each age group according to their responses on questions assessing willingness to seek help if financial barriers were removed.

Table 9

*Age Groups and Help Seeking - Financial Barriers Removed*

Willing to Seek Help if Services available at no cost?	Age Group		
	YY (60-64)	YO (65-74)	OO (75+)
Yes	14 (87.5)	24 (77.4)	17 (43.6)
No	2 (12.5)	7 (22.6)	22 (56.4)

*Note:* Percentages are reported in parentheses.

Binary logistic regression was conducted to assess the effect of age group on the probability that participants would report willingness to seek psychotherapy if the cost of services was covered. In other words, the logistic regression procedure was used to predict whether participants would fall into one of two groups (willing to seek psychotherapy or not willing to seek psychotherapy) based on age group. With age group as the predictor variable, the model was statistically significant,  $\chi^2(2, N=86) = 13.837, p = .001$ , indicating that the model was able to distinguish between participants who answered “yes” or “no” on this survey item. Once again, age group was a significant predictor of whether or not participants would consider seeking mental health services if financial barriers were removed, such that in general, younger age groups reported greater willingness to seek mental health treatment. The model explained between 14.9% (Cox & Snell R Square) and 20.4% (Nagelkerke R Square) of the variance, and correctly classified 69.8% of cases. However, there was also no significant difference between the YY and YO groups on this item. Rather, the significant differences that were observed were between the YY and the OO group, and between the YO and the OO group, such that the YY and the YO group reported greater willingness to seek therapy as compared to the OO group. Results of this logistic regression model are displayed in Table 10.

Table 10

*Logistic Regression Analysis for Willingness to Seek Psychotherapy - Financial Barriers**Removed*

Predictor	<i>B</i>	SE <i>B</i>	Odds Ratio
<i>Reference Group OO</i>			
Age Group			
OO (ages 75+)			
YY (ages 60-64)	-2.204**	.822	.110
YO (ages 65-74)	-1.490**	.537	.225
<i>Reference Group YO</i>			
Age Group			
YO (ages 65-74)			
OO (ages 75+)	1.490**	.537	4.437
YY (ages 60-64)	-.714	.869	.490
Constant	.258	.323	1.294
Chi-Square		13.837	
df		2	

*Note: \*\* $p < .01$ .*

## Hypothesis 4

It was hypothesized that age would be related to willingness to seek help from a clergy member, such that the older group of adults would report greater willingness to seek help from a clergy member. An ANOVA was used to assess the effect of age group on the survey item assessing help seeking from a priest, pastor, or rabbi. There was a significant effect of age on

help seeking from clergy,  $F(2,83) = 3.232$ ,  $p = .044$ . However, post-hoc tests did not reveal any pairwise differences between group means, therefore, there were no significant differences between groups despite a significant omnibus test.

### Exploratory Findings

A series of two-way MANOVAs were performed to assess the effects of demographic variables on attitudes toward psychotherapy and willingness to seek help. These demographic variables included gender, education, marital status, and living arrangement. Income was one demographic variable that was not included in the analyses, as 64 % of participants did not provide an answer to the survey item assessing monthly income. Additionally, race/ethnicity was not included in the analyses as the vast majority of the sample identified as Caucasian/White. The MANOVAs were performed with different combinations of demographic variables included in the analyses. For example, a two-way MANOVA was conducted to assess the effects of gender (with 2 levels) and education (with 7 levels) on the dependent variables of OAK-MHS scores and WSHQ scores. Additionally, a two-way MANOVA was conducted to assess the effects of marital status (with 5 levels) and living arrangement (with 4 levels) on the dependent measures. Regardless of how the variables were entered into the analyses, there were no significant effects found for any demographic variables, with the exception of education. Education had a statistically significant effect on OAK-MHS scores,  $F(6,69) = 1.642$ ,  $p = .050$ , but not WSHQ scores. However, despite a significant omnibus test, post-hoc comparisons did not reveal any significant differences. Tables 11 and 12 detail these findings.

Table 11

*Multivariate Tests- Wilks' Lambda*

Effect	Value	F	df	Error df	Sig. ( $p$ )
Education	.766	1.642	12	138	.087
Gender	.999	.047	2	69	.954
Education x Gender	.900	.748	10	138	.679
Marital Status	.863	1.263	8	132	.268
Living Arrangement	.896	1.237	6	132	.291
Marital x Living	.908	.819	8	132	.587

Table 12

*Tests of Between-Subjects Effects*

Source	Dependent Variable	MS	df	F	Sig. ( $p$ )
Education	OAK-MHS	48.257	6	2.231	.050
	WSHQ	24.239	6	1.271	.282
Gender	OAK-MHS	.212	1	.010	.921
	WSHQ	1.773	1	.093	.761
Education x Gender	OAK-MHS	27.121	5	1.254	.294
	WSHQ	3.891	5	.204	.960
Marital	OAK-MHS	23.573	4	1.159	.337
	WSHQ	36.074	4	2.046	.098
Living	OAK-MHS	30.790	3	1.514	.219
	WSHQ	21.453	3	1.217	.310
Marital x Living	OAK-MHS	11.108	4	.546	.702
	WSHQ	20.681	4	1.173	.331

Because older adults often have less years of education than younger adults, a chi-square test of independence was used to examine the relation between age group and education. The relation between these variables was found to be significant,  $\chi^2(2, N=86) = 9.512, p = .009$ .

Younger age groups were found to have more years of education as compared to older age

groups such that the YY had more education than the YO and the YO had more education than the OO.

Due to the fact that the variables of age and education were correlated, education was included into a MANOVA examining the effect of age group on measures of attitude toward psychotherapy and willingness to seek help. In other words, education was added as a covariate in the model, with age group as the independent variable and total OAK-MHS scores and WSHQ scores as the dependent variables. The inclusion of education as a covariate did not change the initial results presented in Hypothesis 1. Age group was still found to have a significant effect on the OAK-MHS scores but not WSHQ scores. There was no significant effect of education on either dependent measure.

## CHAPTER FOUR

### DISCUSSION

#### Findings

The purpose of this study was to investigate age group differences in older adults' attitudes toward mental health services and willingness to seek such services. Currin et al. (1998) were among the first to examine cohort differences and generational influences on attitudes toward mental health services. Currin et al. found that later-born cohorts of adults (sampled in 1991) demonstrated more positive attitudes as compared to earlier-born cohorts (sampled in 1977). The Currin study provides the empirical basis for the hypothesis that attitudes toward mental health services among older adults will grow increasingly positive with each successive generation.

Although results of the Currin et al. (1998) study provided important information about the impact of attitudinal barriers on the utilization of mental health services by older adults, there were some significant limitations of the study. Primarily, the different cohort groups of older adults were sampled 14 years apart, in 1977 and 1991. This raises the question of whether the attitudinal differences that were found, and attributed to cohort effects, could be partially or completely explained by time of measurement effects. As a result, it was difficult to determine whether attitudinal changes were due to a general cultural shift or if they were actually explained by cohort effects that were specific to older adults. The present study addressed this limitation inherent in the Currin et al. study by examining different generations of older adults at the same historical time period.

In the current study, older adults were examined as a heterogeneous group, with emphasis on the differences that exist between groups of people aged 60 and older. The literature has

begun to distinguish between distinct age groups of older adults, often referred to as the “young old” or “younger old” (YO) and the “older old” or “oldest old” (OO). Baltes and Smith (2003) stated, “old age has two distinct faces,” yet these groups are almost always combined in studies of older adults. In other words, there are noticeable differences between younger and older groups of older adults, yet they are often grouped together in research studies as one “homogenous” group. In light of the generational differences that exist between younger groups of older adults and older groups of older adults, this study examined age group differences (young old versus older old) in attitudes toward psychotherapy and willingness to seek help. An additional pre-retirement younger-young old (YY) group was also included in the analyses for the purposes of making additional comparisons with an up-and-coming generation of older adults.

Based on previous research, it was hypothesized that younger groups of older adults would have more positive attitudes and a greater willingness to seek psychological services as compared to older groups of older adults. Results of this study indicated that age group had a significant effect on attitudes toward psychotherapy as measured by the OAK-MHS, such that the youngest group (YY) reported more positive attitudes toward mental health services than the oldest group (OO). However, there was not a significant difference observed between the YO group (ages 65-74) and the OO group (ages 74+). Rather, the statistically significant difference was observed between the YY group (ages 60-64) and the OO group. These findings are consistent with the notion of a “positive cohort shift”, such that attitudes toward psychotherapy are increasingly positive with each new generation of older adults. In other words, the younger, pre-retirement cohorts of adults were found to have more positive attitudes toward psychotherapy than older cohorts of older adults. However, with no significant difference

observed between the YO generation and the OO generation in this sample, there might not be such drastic differences between different cohorts of adults aged 65 and older with respect to attitudes toward psychotherapy. Rather, the differences that exist are between pre-retirement adults and the oldest group of older adults. The generational change in attitudes toward psychotherapy appears to be between middle-age adults and older adults.

Post-hoc tests revealed that there was no significant effect of age group on willingness to seek help as measured by the WSHQ. It is possible that a different measure of willingness to seek help would have yielded different results. For example, when asked directly about willingness to seek psychotherapy services if barriers to treatment were removed, a significant age group difference was observed with respect to willingness to seek mental health treatment. The youngest group of older adults reported the greatest willingness to seek mental health treatment, while the oldest groups reported statistically lower willingness to seek mental health treatment. This finding suggests that perhaps the best way to measure willingness to seek psychotherapy services is to ask directly about willingness to seek mental health treatment, as opposed to administering a general measure of willingness to seek help, which may possibly tap into other domains. That fact that a significant age group difference was observed when asked directly about willingness to seek psychotherapy services may provide additional evidence for attitudinal differences between various age groups of adults over 60.

Previous experience with psychotherapy was hypothesized to be a variable that could potentially have an effect on attitudes toward psychotherapy and willingness to seek help. Quinn et al. (2009) examined older adults' attitudes toward mental illness and discovered that older adults endorsed a range of positive and negative attitudes toward mental illness. However, Quinn et al. also found that participants with a previous experience with psychotherapy reported

more optimistic attitudes toward mental illness than those participants without a prior psychotherapy experience. Additionally, Kuruvilla, Fenwick, Haque, and Vassilas (2006) found exceptionally positive attitudes toward psychotherapy in an older adult population that was presently receiving mental health services.

This study hypothesized that previous experience with psychotherapy would influence attitudes toward psychological services in a positive direction. It was assumed that attitudes of older adults in all age groups would be increasingly positive when there has been a prior psychotherapy experience. This hypothesis was supported, as there was a significant positive effect of previous experience with psychotherapy on attitudes toward mental health services and willingness to seek help. Furthermore, when previous experience with psychotherapy was considered, there was no longer a significant effect for age, indicating that previous experience with psychotherapy is the variable that appears to explain the observed difference in attitudes toward psychotherapy among older adults. There was no significant interaction between age and previous experience with psychotherapy, such that the effect of previous experience with psychotherapy on attitudes and willingness to seek help did not differ as a function of age group.

Quinn et al. (2009) found that a clinical population of older adults (those receiving mental health treatment) was more likely to have optimistic attitudes toward mental illness as compared to a non-clinical population of older adults (those not receiving mental health treatment). However, Quinn et al. also found that the non-clinical group of older adults was significantly older than the clinical group. Consequently, Quinn et al. could not rule out the possibility that attitudinal differences were the result of cohort effects. Interestingly, the current study also found a significant age group difference in those reporting a previous experience with psychotherapy. Younger groups of adults were significantly more likely to have had a previous

experience with psychotherapy as compared to older groups of adults. In fact, analyses showed that age group was a significant predictor of previous experience with psychotherapy, such that the YY group had more prior experience with mental health treatment than the YO group, and the YO group had more experience than the OO group.

It is possible that younger groups of adults may have increased exposure to mental health treatment as it has become increasingly mainstream, thus contributing to a higher likelihood of having a previous experience with psychotherapy. Currin et al. (1998) imply that cultural and historical forces might have affected attitudes toward mental health services differently in different cohorts of older adults. For instance, Currin asserts that later-born cohorts may have increased exposure to psychological information in the media. The data in the present study also suggest the influence of cultural and historical factors. Although we are examining different age groups of older adults at the same historical time period, the scientific and technological advances that have taken place since the 1950s have likely affected the YO and the OO differently. For example, the YO group was likely in the workforce during the time period in which the Internet was introduced. The YO might have increased familiarity with computers, e-mail access, and other electronic methods of transmitting information as compared with the OO group, thus increasing the likelihood of exposure to up-to-date information about the mental health system. Greater exposure to psychological information in the media and online, and increased awareness of the modern mental health movement may have possibly contributed to a previous experience with psychotherapy, and therefore, more positive attitudes and greater willingness to seek help.

In this sample, a very high percentage of the YY group reported a previous experience with psychotherapy (68.8%). It is possible that there is something fundamentally different about

the adults surveyed at senior centers that might have produced this very high percentage of pre-retirement adults with a previous experience with psychotherapy. First of all, it is possible that more adults with a previous experience with psychotherapy agreed to take part in the study, while older adults without a psychotherapy experience declined to participate. Secondly, it is possible that the pre-retirement adults present at senior centers were lower functioning than other pre-retirement working adults who were not present at senior centers, thus contributing to a higher likelihood of psychotherapy experience in this particular pre-retirement group.

Nevertheless, results of this study indicate that age group is a significant predictor of personal experience with psychotherapy. Therefore, it is possible that age group differences in attitudes toward mental health treatment can be accounted for by previous experience with psychotherapy, as younger adults have more therapy experience. This finding is considered to be important because it is possible that different generations' attitudes might not be so fundamentally different after all, but rather, older generations have simply had less exposure to psychotherapy than younger generations. The difference that was observed might not be an attitudinal difference, but an exposure difference instead. Another possibility is that exposure to psychotherapy is something that changes attitudes in a positive direction, such that there is an attitudinal difference between generations that has been influenced by different levels of therapy exposure in these different groups. The mental health field has grown in recent decades. It is possible that the increased availability of psychological services over time has differentially affected different cohorts of older adults, such that younger adults were more likely to have a previous experience with psychotherapy as compared to older adults.

Previous research has suggested that a variety of barriers may contribute to low mental health service utilization among older adults. Woodward and Pachana (2009) suggest that older

adults may experience difficulties with the affordability and accessibility of psychotherapy services. Transportation and cost were thought to be significant barriers to treatment in an older adult population. This study hypothesized that younger groups of older adults would report greater willingness to seek psychotherapy services if barriers were removed as compared to older adults. Findings showed that a greater percentage of the OO group was affected by transportation barriers as compared to the YY and YO groups. However, results also highlighted an important age group difference in service utilization and barriers to treatment. There was a significant age group difference in reported willingness to seek psychotherapy services if transportation barriers were removed, such that the youngest group of adults (YY) was significantly more willing to seek psychological services as compared to the oldest group of adults (YO and OO group).

Surprisingly, 18.8% of the YY group, 32.2% of the YO group, and 58.1% of the OO group stated that they would *not* consider seeking psychotherapy services, even if transportation was provided. In other words, more than half of the oldest groups of older adults would not consider seeking psychotherapy services even if they did not have to worry about transportation. This finding demonstrates a fundamental difference between groups in willingness to seek mental health treatment. On the other hand, approximately 42% of the OO group would consider seeking psychotherapy if transportation barriers were removed. Due to the fact that transportation issues affected a greater percentage of the OO group, these results suggest that transportation may actually be a meaningful barrier to treatment in the oldest group of adults (OO). It is important to note that there was no significant difference between the YY and the YO group on this survey item, perhaps suggesting that transportation barriers do not affect the younger groups of older adults to the same extent as the older groups of adults.

With respect to financial barriers to treatment, 41.9 % of the total sample indicated that economic problems prevent them from seeking professional services. As compared to the 20.9% of the total sample that endorsed problems with transportation as a barrier to services, a greater percentage of the total sample endorsed economic problems as a barrier treatment. Therefore, in this sample it can be inferred that economic issues are greater perceived barriers to treatment than transportation issues. Out of the 41.9 % of the total sample that acknowledged economic problems as a barrier to treatment, 27.7 % belong to the YY group, 38.9 % belong to the YO group, and 33.3 % belong to the OO group. Interestingly, the YO group appeared to be the most affected by financial barriers to treatment. This could be due to greater economic problems and less financial stability in the YO group as compared to pre-retirement adults (YY) and the oldest group of adults (OO), perhaps reflecting a specific stressor that is faced during retirement age.

Similar to transportation barriers to treatment, there was a significant age group difference in reported willingness to seek psychotherapy services if financial barriers were removed, such that the youngest group of adults was more willing to seek psychotherapy services as compared to the oldest group of adults. Results showed that 12.5% of the YY, 22.5% of the YO, and 56.4% of the OO would not consider seeking psychotherapy services even if the cost of services was covered. This represented a statistically significant difference between groups; however, there was no significant difference observed between the YY and YO groups on this survey item. Again, more than half of the oldest group of adults would not consider seeking psychotherapy services, even if they did not have to worry about the cost of such services. Although a significant age group difference was anticipated with respect to barriers to treatment, it was surprising to discover the percentage of older adults in this sample who would not consider seeking psychotherapy even if specific barriers to treatment were removed. These

findings suggest that barriers to treatment including transportation and cost may not fully explain low service utilization among older adults. In fact, attitudes toward mental health treatment may in fact be one of the most significant barriers to treatment among the oldest groups of adults.

### Limitations and Future Directions

It is important to note that some of the characteristics of the sample used in this study may limit the generalizability of the findings. The sample was comprised almost exclusively of Caucasian participants (90%), with another 5.8 % of the sample not providing a response to the question assessing race/ethnicity. In a study of Korean-American older adults' attitudes toward mental health, Jang, Chiriboga, and Okazaki (2009) found that culturally influenced beliefs had a substantial contribution to attitudes toward mental health. Additionally, a study of attitudes toward mental illness in an African American population indicated that older adults had low service utilization in the past, and little intention for mental health service utilization in the future. It can be assumed that some important data was missing in this study as a result of the homogeneity of race/ethnicity of participants. Furthermore, participants in this study were sampled in rural areas of western Pennsylvania. It is possible that different results might have been obtained with an urban-dwelling population of older adults.

Another factor to consider is the setting in which older adults in this study were sampled. Older adults in the current study were sampled in senior centers during lunch hours. Older adults at senior centers are thought to represent a middle ground between very high and very low functioning older adults. For example, individuals were only included in this study if they were capable of completing a pencil-and-paper survey. It is possible that individuals with reading, writing, and/or cognitive difficulties did not volunteer to participate, despite being offered help in completing the survey. Therefore, very low functioning older adults were likely not included

in the study. Conversely, the primary investigator surveyed older adults in senior centers during afternoon hours and, it is possible that older adults in the workforce were not present at senior centers during the daytime, and were not surveyed. As a result, it is also possible that a population of very high functioning, working older adults were not included in this study. Future research should include a more diverse sample of older adults.

However, there are several strengths of the sample that was included in this study. Older adults sampled at senior centers were diverse with respect to gender, living arrangement, education, and marital status. The age range included in the study was very large; including adults aged 60 to 96. The different age groups of older adults (YY, YO, and OO) were also fairly evenly represented in the sample, allowing for comparisons to be made between different age groups of older adults.

There is very limited research on the psychometric properties of either instrument: the OAK-MHS or the WSHQ. The OAK-MHS was one of the only tools available in the research literature for measuring attitudes toward psychotherapy in an older adult population. Furthermore, there was very little research available on measurement of willingness to seek help in the general population, much less with an older adult population. The shortage of available instruments for measuring attitudes and willingness to seek help highlights an important direction for future research. In order to understand underutilization of mental health services in an older adult population, we must have well-validated tools for measurement of attitudes and willingness to seek help. Additionally, these instruments should have more developed norms for an older adult population. Future research should focus on the development and validation of measures for the assessment of attitudes toward psychotherapy and willingness to seek help.

In discussing the limitations of this study, it is important to discuss the limitations inherent in self-report measures, and especially the self-report of previous experience with psychotherapy. Due to the fact that the primary investigator was present in the room during the survey, it is possible that participants could have answered questions in a way that made them appear favorably to the researcher. Additionally, the survey was administered with respondents sitting very close to their friends and acquaintances. As a result, individuals might have answered survey questions in a way that made them appear favorably to their peers. It is possible that individuals' responses could have been affected by the responses of their peer group, contributing to a "group mentality" in responding to the survey.

Previous experience with psychotherapy was also determined by participants' self-report. Participants who are ashamed or embarrassed about a previous experience with psychotherapy may be reluctant to disclose this information on a survey. Khurgin-Bott and Farber (2011) asserted that patient disclosure *about* therapy to others outside of the mental health treatment setting has rarely been studied. These researchers found that patients only tend to be moderately willing to discuss their therapy experiences with spouses, significant others, and best friends. Khurgin-Bott and Farber also found that patients tend to withhold material about therapy because they consider these details to be too private or shameful. Future research should focus on older adults' disclosures of previous psychotherapy experience. Research should consider whether the oldest groups of adults are more reluctant to disclose a prior experience with therapy as compared to their younger counterparts.

In the current study, it is possible that only participants with the most positive attitudes toward psychotherapy actually disclosed their previous experience with psychotherapy, thus contributing to the observed relationship between positive attitudes and previous experience with

psychotherapy. A total of 26 participants (30% of the total sample) acknowledged having a previous personal experience with psychotherapy, and only 4 of these participants were in the OO group. In other words, only 10% of the OO group reported a prior psychotherapy experience. In 2001, the Department of Health and Human Services Administration on Aging reported that only 20% of older adults acknowledged a mental health problem, and only half of these adults acknowledging a mental health problem reported seeking mental health services. The data in the current study is consistent with the aforementioned rates of service use among older adults. Additionally, it appears that the rates of service use have not changed dramatically over the past 10 years. Considering the attitudinal differences that were found in this study, it is likely that rates of service use will increase over the next 10 years, as the baby boomer generation is entering retirement.

It is possible that the stigma attached to receiving mental health treatment may have affected rates of disclosure about psychotherapy experience in the oldest group of adults. Future research on older adults' disclosures of psychotherapy experience may provide additional useful information about the stigma that is attached to receiving mental health services in this unique population. In discussing older adults attitudes toward psychotherapy and willingness to seek help, an additional future research question would involve the investigation of older adults attitudes toward working with a much younger therapist. It can be assumed that as individuals reach the oldest levels of age, the likelihood of a significant client-therapist age gap will also grow. Future research should focus on older adults' attitudes toward working with a younger therapist, as this may be an additional barrier to treatment.

The implications of this study that suggest several areas for future research. The youngest group of pre-retirement adults was found to have significantly more positive attitudes

toward psychotherapy services as compared to the oldest group of adults. However, this youngest group of adults was also significantly more likely to have had previous exposure to psychotherapy. This raises the question of the importance of previous exposure to psychotherapy, and it suggests a valuable area for future research. Additional comparisons should be made with younger adults and youth with respect to exposure to psychotherapy and the possible influence of previous experience with psychotherapy on attitudes toward mental health treatment. Would previous experience with psychotherapy influence attitudes toward seeking psychotherapy services in all age groups (children, adolescents, young adults, etc.)? Furthermore, this question could be expanded for research with different groups of people, including various cultural groups who typically have low mental health service utilization.

### Conclusion

This study intended to explore older adults' attitudes towards psychotherapy and willingness to seek help, and persistence of stigma attached to mental health treatment in various age groups of older adults. Results of the study suggested that older groups of adults generally hold more negative attitudes toward psychotherapy, and are less likely to have had a previous experience with psychotherapy. Personal experience with psychotherapy was highly related to positive attitudes toward mental health treatment and greater willingness to seek help. Age group was also a predictor of previous experience with psychotherapy. In general, the youngest groups of adults appeared to have the greatest levels of exposure to the mental health system.

The results of this study have several important implications. For instance, contrary to previous assumptions about barriers to treatment in an older adult population, results of this study indicated that barriers including transportation and finances do not appear to influence older adults' decisions to seek psychotherapy, especially in the oldest groups of adults. In fact,

lack of exposure to the mental health system might be the greatest barrier to treatment with this age group. This study is important because we now know that we must increase exposure to mental health services in order to potentially affect attitudes toward psychotherapy and willingness to seek help, particularly in the older adult population. Due to the fact that psychiatric treatment involving drug therapy is often contraindicated for older adults, psychotherapy is a highly desirable and vitally important treatment option. Education and increased exposure to mental health treatment through media outlets that target the oldest groups of adults might be the best way to reduce stigma attached to receiving mental health services in this population. Common mental health problems in older adulthood should be normalized, and the benefits of psychotherapy for this population should be promoted. Future research should focus on the most effective ways provide older adults with accurate, up-to-date information about psychotherapy as a treatment for common issues in late adulthood.

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## APPENDIX A

QUESTIONS ADAPTED FROM THE OLDER ADULTS' ATTITUDES AND KNOWLEDGE TOWARD SEEKING MENTAL HEALTH SERVICES SCALE (OAK-MHS) (Lundervold & Young, 1992)

1.) An older adult who feels nervous, tense, or depressed, should only talk to family members about these feelings.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

2.) An older adult who feels worried, nervous, or depressed, is likely going crazy.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

3.) An older adult who feels depressed, nervous, or worried is able to change the way he or she feels.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

4.) When you get to be 55 years of age or older, you naturally start to feel sad, blue, and depressed.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

5.) An older adult who sees a counselor or psychologist because he or she feels confused and depressed is a weak person.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

6.) Psychological counseling can help an older adult change the way he or she thinks, feels, and behaves.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

7.) An older adult who sees a counselor because he or she is worried and depressed will likely be forced to live in a nursing home or state hospital.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

8.) If I were depressed and worried, money problems would prevent me from seeing a counselor.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

9.) Going to see a counselor or psychologist in his or her office is embarrassing.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

10.) An older adult who has difficulty remembering certain things and sometimes acts confused can be helped by a counselor or psychologist.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

11.) An older adult who feels depressed and worried can only be helped if he or she believes in God.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

12.) An older adult feels depressed, confused, or lonely should talk to a psychologist.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

13.) Psychological treatment for older adults feeling depressed, sad, or blue can be effective.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

14.) Medicare will likely pay for services provided by a psychologist.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

15.) If an older adult feels depressed, lonely, and worried, it means God is testing his or her faith.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

16.) If I were depressed, I would prefer in-home visits by a counselor or psychologist.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

17.) An older adult who loses interest and pleasure in most of his or her activities can be helped by a counselor or psychologist.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

18.) When you get to be 55 years of age or older, you naturally start to feel anxious, tense, and worried.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

19.) An older adult who feels nervous, tense, or depressed should only talk to his or her priest, pastor, or rabbi.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

20.) Have you ever in your lifetime sought professional psychological counseling?

YES

NO

## APPENDIX B

## QUESTIONS ADAPTED FROM THE WILLINGNESS TO SEEK HELP QUESTIONNAIRE (WSHQ) (Cohen, 1999)

1.) I would want someone to know if I were feeling fearful.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

2.) I am aware that I might have a problem, such as a physical disability, that cannot be treated without professional help.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

3.) I would want an expert to help me if I were feeling anxious or fearful.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

4.) When something at home is broken, I usually try to fix it myself, even if it involves wasting time and money.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

5.) If I were experiencing a problem coping with the loss of a loved one, I would need to make sure no one knew about it.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

6.) If I were experiencing a psychological problem, such as depression or anxiety, I would want an expert to advise me.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

7.) Some problems are so distressing that one cannot deal with them alone.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

8.) If I were experiencing a psychological problem, I would need to make sure no one knew about it.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

9.) I am aware that some fears are not likely to go away on their own.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

10.) I would want an expert to help me if I were experiencing a problem, such as a physical disability.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

11.) I would want an expert to help me if I were experiencing a problem coping with the loss of a loved one.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

12.) If I were distressed about a physical illness, I would need to make sure no one knew about it.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

13.) I am aware of the possibility that I might have a problem with bereavement or grief that I cannot solve on my own.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

14.) Some psychological problems, such as depression or anxiety, require professional help.

STRONGLY AGREE      AGREE      DISAGREE      STRONGLY DISAGREE

## APPENDIX C

## ADDITIONAL QUESTIONS

1.) Has a close family member or friend ever sought professional psychological counseling?

YES

NO

2.) Is access to transportation an issue that sometimes prevents you from seeking professional services?

YES

NO

3.) If reliable transportation was provided, or was not a concern, would you be willing to seek professional mental health services for a psychological problem such as depression or anxiety?

YES

NO

4.) Do financial issues sometimes prevent you from seeking professional services?

YES

NO

5.) If you knew that professional mental health services were available at little to no cost, would you consider seeking such services for a problem such as depression or anxiety?

YES

NO

## APPENDIX D

## DEMOGRAPHIC QUESTIONS

- 1.) Please select the option that best describes your current living arrangement:
  - a.) Independently living with family members and/or partner
  - b.) Assisted Living Facility
  - c.) Nursing Home
  - d.) Independently living alone
  - e.) Other
  
- 2.) Please provide an estimate of your monthly household income:     \$ \_\_\_\_\_
  
- 3.) Please select your current marital status:
  - a.) Married
  - b.) Divorced
  - c.) Separated
  - d.) Single/ Never married
  - e.) Widowed
  - f.) Other
  
- 4.) What is your date of birth? \_\_\_\_\_ What is your age? \_\_\_\_\_
  
- 5.) Please circle the highest level of education that you have completed:
  - a.) Grade school
  - b.) Some high school
  - c.) High school graduate
  - d.) Vocational or technical school
  - e.) Some college
  - f.) College graduate
  - g.) Graduate or professional school
  
- 6.) Please circle your sex/gender:     Male            Female
  
- 7.) Please select your race/ethnicity:
  - a.) African Origin/ Black
  - b.) Hispanic/Latino(a)
  - c.) Asian/Pacific Islander
  - d.) Native American/ Indian
  - e.) Caucasian (non-Hispanic) / White
  - f.) Biracial
  - g.) Other

## APPENDIX E

## Senior Center Survey

*For the following items, please circle either:*

*a.) STRONGLY AGREE, b.) AGREE, c.) DISAGREE, or d.) STRONGLY DISAGREE*

1.) An older adult who feels nervous, tense, or depressed, should only talk to family members about these feelings.

a.) STRONGLY AGREE

c.) DISAGREE

b.) AGREE

d.) STRONGLY DISAGREE

2.) An older adult who feels worried, nervous, or depressed, is likely going crazy.

a.) STRONGLY AGREE

c.) DISAGREE

b.) AGREE

d.) STRONGLY DISAGREE

3.) An older adult who feels depressed, nervous, or worried is able to change the way he or she feels.

a.) STRONGLY AGREE

c.) DISAGREE

b.) AGREE

d.) STRONGLY DISAGREE

4.) When you get to be 55 years of age or older, you naturally start to feel sad, blue, and depressed.

a.) STRONGLY AGREE

c.) DISAGREE

b.) AGREE

d.) STRONGLY DISAGREE

5.) An older adult who sees a counselor or psychologist because he or she feels confused and depressed is a weak person.

a.) STRONGLY AGREE

c.) DISAGREE

b.) AGREE

d.) STRONGLY DISAGREE

6.) Psychological counseling can help an older adult change the way he or she thinks, feels, and behaves.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

7.) An older adult who sees a counselor because he or she is worried and depressed will likely be forced to live in a nursing home or state hospital.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

8.) If I were depressed and/or worried, money problems would prevent me from seeing a counselor.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

9.) Going to see a counselor or psychologist in his or her office is embarrassing.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

10.) An older adult who has difficulty remembering certain things and sometimes acts confused can be helped by a counselor or psychologist.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

11.) An older adult who feels depressed and worried can only be helped if he or she believes in God.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

12.) An older adult who feels depressed, confused, or lonely should talk to a psychologist.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

13.) Psychological treatment for older adults feeling depressed, sad, or blue can be effective.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

14.) Medicare will likely pay for services provided by a psychologist.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

15.) If an older adult feels depressed, lonely, and worried, it means God is testing his or her faith.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

16.) If I were depressed, I would prefer in-home visits by a counselor or psychologist.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

17.) An older adult who loses interest and pleasure in most of his or her activities can be helped by a counselor or psychologist.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

18.) When you get to be 55 years of age or older, you naturally start to feel anxious, tense, and worried.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

19.) An older adult who feels nervous, tense, or depressed should only talk to his or her priest, pastor, or rabbi.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

20.) I would want someone to know if I were feeling fearful.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |



26.) Some problems are so distressing that one cannot deal with them alone.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

27.) If I were experiencing a psychological problem, I would need to make sure no one knew about it.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

28.) I am aware that some fears are not likely to go away on their own.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

29.) I would want an expert to help me if I were experiencing a problem, such as a physical disability.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

30.) I would want an expert to help me if I were experiencing a problem coping with the loss of a loved one.

- |                    |                       |
|--------------------|-----------------------|
| a.) STRONGLY AGREE | c.) DISAGREE          |
| b.) AGREE          | d.) STRONGLY DISAGREE |

31.) If I were distressed about a physical illness, I would need to make sure no one knew about it.

- a.) STRONGLY AGREE                      c.) DISAGREE  
b.) AGREE                                      d.) STRONGLY DISAGREE

32.) I am aware of the possibility that I might have a problem with bereavement or grief that I cannot solve on my own.

- a.) STRONGLY AGREE                      c.) DISAGREE  
b.) AGREE                                      d.) STRONGLY DISAGREE

33.) Some psychological problems, such as depression or anxiety, require professional help.

- a.) STRONGLY AGREE                      c.) DISAGREE  
b.) AGREE                                      d.) STRONGLY DISAGREE

*For the following items, please circle either: a.) YES, or b.) NO*

1.) Is access to transportation an issue that sometimes prevents you from seeking professional services?

- a.) YES                                      b.) NO

2.) Do financial issues sometimes prevent you from seeking professional services?

- a.) YES                                      b.) NO

3.) Have you ever in your lifetime sought professional psychological counseling?

- a.) YES                      b.) NO

4.) Has a close family member or friend ever sought professional psychological counseling?

- a.) YES                      b.) NO

5.) If reliable transportation was provided, or was not a concern, would you be willing now to seek professional mental health services for a problem such as depression or anxiety?

- a.) YES                      b.) NO

6.) If you knew that professional mental health services were available at little to no cost, would you consider seeking such services for a psychological problem such as depression or anxiety?

- a.) YES                      b.) NO

*Please provide an answer for the following demographic questions:*

1.) Please select the option that best describes your current living arrangement:

- a.) Living with family members and/or partner
- b.) Assisted Living Facility
- c.) Nursing Home
- d.) Independently living alone
- e.) Other

2.) Please provide an estimate of your monthly household income:

\$ \_\_\_\_\_

3.) Please select your current marital status:

- a.) Married
- b.) Divorced
- c.) Separated
- d.) Single/ Never married
- e.) Widowed
- f.) Other

4.) What is your date of birth? \_\_\_\_\_ What is your age? \_\_\_\_\_

5.) Please circle the highest level of education that you have completed:

- a.) Grade school
- b.) Some high school
- c.) High school graduate
- d.) Vocational or technical school
- e.) Some college
- f.) College graduate
- g.) Graduate or professional school

6.) Please circle your sex/gender:      Male                  Female

7.) Please select your race/ethnicity:

- a.) African Origin/ Black
- b.) Hispanic/Latino(a)
- c.) Asian/Pacific Islander
- d.) Native American/ Indian
- e.) Caucasian (non-Hispanic)/ White
- f.) Biracial
- g.) Other

## APPENDIX F

Informed Consent Letter

You are invited to participate in this research study through Indiana University of Pennsylvania. The following information is provided in order to help you to make an informed decision regarding whether or not to participate. If you have any questions please do not hesitate to ask.

The purpose of this study is to gather information regarding older adults' attitudes about issues related to professional services. You will be asked to respond to a number of survey items, in which you will be able to express your attitudes. You will also be asked a few questions about your own personal experiences. This process should take approximately 20 minutes. Your participation in this study is strictly voluntary. You are free to decide not to participate in this study, or to withdraw at any time, without adversely affecting your relationship with the investigator(s) or IUP. Furthermore, your decision will not result in any loss of benefits to which you are otherwise entitled. If you choose to participate, you may withdraw at any time by notifying the Project Director or the individual administering the study. Upon your request to withdraw, all information pertaining to you will be destroyed. Your response will be considered only in combination with those from other participants, and your identity will remain confidential even to the researchers. The information obtained in the study may be published in scientific journals or presented at scientific meetings, but your identity will be kept strictly confidential.

If you agree to participate in the study, simply fill-out the survey when it is distributed. If you do not agree to participate, you can choose to decline the survey when it is distributed, or you can leave the survey blank. When you are finished taking part in the study, you will be given a referral sheet providing you with contact information for counseling services, which can be used in the event that you feel the need to discuss any issues that may have arisen from participation in this study. However, it is important to note that there are no known risks associated with participation in this study.

To receive further information please contact:

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