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## Intrinsic and extrinsic barriers to mental health care among community-dwelling younger and older adults

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This study examined intrinsic and extrinsic barriers to mental health care among younger ( $n = 76$ ;  $M$  age = 23 years) and older adults ( $n = 88$ ;  $M$  age = 71 years) using a new 56 item self-report measure, Barriers to Mental Health Services Scale (BMHSS). The BMHSS was developed to examine 10 barriers to the utilization of mental health services: help-seeking attitudes, stigma, knowledge and fear of psychotherapy, belief about inability to find a psychotherapist, belief that depressive symptoms are normal, insurance and payment concerns, ageism, concerns about psychotherapist's qualifications, physician referral, and transportation concerns. Results indicated that younger adults perceived fear of psychotherapy, belief about inability to find a psychotherapist, and insurance concerns to be greater barriers than older adults. Men perceived stigma to be a greater barrier than women whereas women perceived finding a psychotherapist to be a greater barrier than men. The rank order of the BMHSS subscales was strongly similar for younger and older adults ( $r = 0.90$ ,  $p = 0.000$ ). These results also provide further evidence that stigma about receiving mental health services is not a primary barrier among younger or older adults.

**Keywords:** elderly; age differences; barriers; psychotherapy; service utilization

Older adults underutilize mental health services to a great extent despite evidence demonstrating their need for such services (Crabb & Hunsley, 2006; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002; Robb, Haley, Becker, Polivka, & Chwa, 2003). According to Robb and colleagues, younger adults are two times more likely than older adults to have visited a mental health professional and are more knowledgeable about mental health topics. Variations in service utilization are also seen within the older adult population with young-old adults reporting having used more mental health services than old-old adults (Currin, Hayslip, Schneider, & Kookon, 1998). Several possible deterrents or barriers to the use of mental health services have been identified, including attitudes and beliefs older adults have regarding mental health, physical accessibility, and insurance coverage. In general, barriers to mental health services can be separated into two domains: intrinsic and extrinsic. Intrinsic barriers are those that operate within an individual, whereas extrinsic barriers are those that are outside of an individual. It is likely that these barriers do not operate independently but co-occur in a system. For example, an older adult may have a negative view of mental illness (an intrinsic barrier), limited knowledge about the potential benefits of psychotherapy (another intrinsic barrier), limited monetary resources (an extrinsic barrier), and limited

options for transportation to the mental health professional's office (another extrinsic barrier).

Some specific *intrinsic* barriers to seeking mental health services among older adults include help seeking behavior, stigma, knowledge and fear of psychotherapy, and the belief that depressive symptoms are normal. Several researchers (e.g., Hadas & Midlarsky, 2000; Robb et al., 2003; Waxman, Carner, & Klein, 1984) identified help seeking behaviors and associated attitudes as contributing to older adult's low utilization rates of mental health services, specifically that older adults feel responsible for solving their own problems and that older adults report being less likely to consult with a mental health provider regarding depression and anxiety. Waxman et al. (1984) identified stigma associated with mental illness and mental health services as a meaningful obstacle among community dwelling older adults, but this issue remains controversial. For example, in a cross-sectional study, Segal, Coolidge, Mincic, and O'Riley (2005) found that older adults held some potentially pejorative views of the mentally ill compared to younger adults, viewing individuals with mental illness as being more socially unskilled, embarrassing, and socially disagreeable, but older adults did not differ from younger adults in their perception regarding the incurability of mental illness and the dangerousness of those who are mentally ill, nor did younger and older adults differ in their general

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willingness to seek psychological help. Even among older adults, there are some differences in stigma. Currin et al. (1998) found young-old adults to be less rigid and stereotypical in their thinking about mental illness than old-old adults.

According to Lasoski and Thelen (1987), older adults generally recognize the symptoms of mental illness, but were less likely than middle-aged adults to view outpatient services as appropriate treatment and more likely than middle-aged adults to lean toward inpatient interventions. Researchers (Crabb & Hunsley, 2006; Sarkisian, Lee-Henderson, & Mangione, 2003) have also suggested that some older adults perceive depression as a normal part of aging and therefore believe that symptoms of a depressive nature not worth reporting to a professional, indicating yet another important barrier.

In contrast to intrinsic barriers, *extrinsic* barriers operate outside of an individual seeking mental health services and include insurance and payment concerns, ageism, a lack of qualified mental health providers, physician referral, and difficulty with transportation. According to Robb, Chen, and Haley (2002), older adults identify financial issues as the chief obstacle to mental health treatment. Indeed, many older adults participate in insurance systems that are separate and different from the general population (Norris, Molinari, & Rosowsky, 1998) and these systems have reimbursement policies that historically have discouraged some mental health clinicians from working with older adults (Barrick, Karuza, & Dundon, 1995). Ageist attitudes held by mental health professionals (James & Haley, 1995; Robb et al., 2002) and government administration (Robb et al. 2002) may also limit the services available for some older adults. Clinicians specializing in older adults and training programs dedicated to train these professionals are scarce despite a clear need (Qualls, 1998; Qualls et al., 2002; Qualls, Segal, Benight, & Kenny, 2005). It has been well documented that when many older adults seek help for mental health problems, they typically visit their primary care physician or family doctor, not a mental health professional (Jeste et al., 1999; Mackenzie, Gekoski, & Knox, 2006; Robb et al., 2003; Waxman et al., 1984) representing yet another barrier if older adults do not receive or accept an appropriate referral.

The important role of gender as it relates to the underutilization of mental health services has also been examined. In general, the findings suggest that women are considerably more open to and more willing to seek out mental health services compared to men (Hauenstein et al., 2006; Mackenzie et al., 2006; Rhodes, Goering, To, & Williams, 2002) and that men are likely to have negative attitudes about mental health services which contributes to their low utilization rates (Mackenzie et al., 2006). However, gender has infrequently been considered in studies of barriers in later life.

A potentially important gap in the extant literature regarding barriers to mental health services are studies that examine a broad variety of barriers among younger and adults and among men and women. The purpose of the present study was to create an instrument to examine a wide range of intrinsic and extrinsic barriers for use in studies across the adult lifespan. The first specific aim of the study was to explore whether age-differences in barriers exist between the young adults and older adults, a second aim was to explore whether age-differences in barriers exist between the young-old and old-old, and a third aim was to examine the impact of gender in the age group analyses.

## Method

### *Participants and procedure*

Undergraduate students were recruited from psychology classes. They received extra credit for their participation. Older adults were recruited through a research database and participated at a research site in the community. Older adult participants were paid \$10 for their participation. Participants ( $N = 164$ ) anonymously completed the questionnaire packet in large groups. Two groups were formed based on age.

### *Younger adults*

The young adult group was comprised of 76 students enrolled in psychology classes ( $M$  age = 23.0 years,  $SD = 4.5$ , age range = 18 to 35 years; 67% female; 78% Caucasian). Education ranged from 12 to 18 years ( $M = 14.1$  years,  $SD = 1.7$  years).

### *Older adults*

The older adult group was comprised of 88 community dwelling individuals ( $M$  age = 74.8 years,  $SD = 7.3$ , age range = 61 to 90 years; 68% female; 100% Caucasian). Education ranged from 8 to 24 years ( $M = 14.3$  years,  $SD = 2.9$  years).

### *Equivalence of age groups*

To determine if younger and older age groups varied significantly on gender and ethnicity, two chi square analyses were computed. The proportion of female participants did not differ significantly in the younger (67%) or the older groups (68%),  $\chi^2(2, N = 154) = 1.12, p = 0.57$ . The younger group was more ethnically diverse with the proportion of participants who self-identified as Caucasian in the younger group (78%) being significantly lower than the older group (100%),  $\chi^2(1, N = 164) = 21.96, p = 0.00$ . Regarding education, years of education for younger adults ( $M = 14.1$ ,  $SD = 1.7$ ) was not significantly different from years of education for older adults ( $M = 14.3$ ,  $SD = 2.9$ ),  $t(161) = -0.78, p = 0.44$ . Thus the two age groups were

similar in gender proportions and average years of education but differed regarding the proportions of ethnicity.

### Measure

The Barriers to Mental Health Services Scale (BMHSS) was created for this study. It is a self-report questionnaire consisting of 56 items designed to measure a wide range of barriers prohibiting individuals from seeking mental health services. Participants rate the extent to which they agree to each item on a 5-point Likert scale from ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). There are 10 subscales on the BMHSS representing obstacles identified from reviewing the literature regarding barriers to accessing mental health services and from our clinical experiences. Over 200 items were initially created and presented to geropsychology professionals to improve item content and reduce redundancy. The remaining 63 core items were included during data collection. Then, based on inter-item correlations an additional seven items were removed to improve internal consistency of the subscales. To standardize the subscales, each is calculated as the sum of the responses to the items divided by the number of items on each subscale. The subscales can be summed to provide a total score. Higher scores on all subscales indicate a higher degree of the perceived barrier. As a conceptual expedient, subscales on this measure are divided into two domains, intrinsic barriers and extrinsic barriers. The five intrinsic barrier subscales include: help seeking, stigma, knowledge and fear of psychotherapy, belief about inability to find a psychotherapist, and belief that depressive symptoms are normal. These intrinsic subscales can be summed to form an intrinsic total score. The five extrinsic barrier subscales include: insurance and payment concerns, ageism, concerns about psychotherapist's qualifications, physician referral, and transportation concerns. These extrinsic subscales can be summed to form an extrinsic total score. A general description of these subscales, the number of items on each subscale, and a representative item for each subscale are presented in Table 1.

## Results

### Internal consistency

The reliabilities of the BMHSS total score, intrinsic total score, extrinsic total score, and the 10 BMHSS subscale scores were examined using Cronbach's alpha. The alphas for the 10 subscales (in order) are as follows: belief that depressive symptoms are normal (0.48), physician referral (0.61), belief about inability to find a psychotherapist (0.69), concerns about psychotherapist's qualifications (0.69), ageism (0.73), stigma (0.73), transportation concerns (0.73), knowledge and fear of psychotherapy (0.74), help seeking (0.75), and insurance and payment concerns (0.78).

The alphas for the intrinsic total score (0.86), extrinsic total score (0.80) and BMHSS total score (0.90) were all good.

### Age and gender effects on the BMHSS

A series of two-way ANOVAs was conducted to examine the effects of age group (young adults compared to older adults) and gender as well as the interactions of age group and gender on the BMHSS total score, intrinsic barriers score, extrinsic barriers score, and the 10 subscales.

#### Age by gender interactions

ANOVA revealed two statistically significant interactions. The first interaction was on the extrinsic barriers scale,  $F(1, 144) = 4.36$ ,  $p = 0.01$  with a small to moderate effect size ( $\eta^2 = 0.05$ ). Follow up *t*-tests revealed that younger men ( $M = 12.57$ ,  $SD = 1.96$ ) scored significantly higher than older men ( $M = 11.16$ ,  $SD = 1.73$ ),  $t(46) = 2.66$ ,  $p = 0.01$ , whereas younger women ( $M = 11.67$ ,  $SD = 1.65$ ) were not significantly different than older women ( $M = 11.82$ ,  $SD = 1.58$ ).

The second significant interaction was on the physician referral subscale,  $F(1, 147) = 6.50$ ,  $p = 0.004$  with a moderate effect size ( $\eta^2 = 0.06$ ). Follow up *t*-tests revealed that younger men ( $M = 2.59$ ,  $SD = 0.67$ ) scored significantly higher than older men ( $M = 2.03$ ,  $SD = 0.53$ ),  $t(46) = 3.27$ ,  $p = 0.002$ , whereas younger women ( $M = 2.15$ ,  $SD = 0.56$ ) were not significantly different than older women ( $M = 2.19$ ,  $SD = 0.61$ ).

#### Age effects

Significant main effects were found for age on the BMHSS total score,  $F(1, 140) = 4.81$ ,  $p = 0.03$ , intrinsic barriers scale,  $F(1, 144) = 5.81$ ,  $p = 0.02$ , and extrinsic barriers scale,  $F(1, 144) = 4.56$ ,  $p = 0.04$ , with younger adults scoring higher than older adults on each of these scales. Significant main effects were also found on four subscales: knowledge and fear of psychotherapy subscale,  $F(1, 146) = 5.11$ ,  $p = 0.03$ , belief about inability to find a psychotherapist subscale,  $F(1, 146) = 4.06$ ,  $p = 0.05$ , insurance and payment concerns subscale,  $F(1, 145) = 18.30$ ,  $p = 0.00$ , and physician referral subscale,  $F(1, 147) = 6.50$ ,  $p = 0.01$ . All effects were in the same direction with younger adults perceiving significantly higher levels of each barrier than older adults (see Table 2 for means and effect sizes).

#### Gender effects

There were two significant main effects for gender, on the stigma subscale  $F(2, 146) = 5.48$ ,  $p = 0.01$  with men ( $M = 2.25$ ,  $SD = 0.66$ ) reporting that stigma is a significantly greater barrier than women ( $M = 1.95$ ,  $SD = 0.61$ ), with a moderate effect size ( $\eta^2 = 0.07$ ) and on the belief about inability to find a psychotherapist subscale  $F(2, 146) = 3.34$ ,  $p = 0.04$  with women

Table 1. BMHSS subscales (number of items on each subscale), scale definitions, and sample items.

Subscale (# items)	Definition	Sample item
Help seeking (12)	Assesses the general help seeking attitudes and behaviors of participants.	I would not go to psychotherapy because a person's problems are his or her own business, not anybody else's.
Stigma (5)	Assesses participants' views of mental illness and its treatment, specifically, psychotherapy.	I would not go to a psychotherapist because normal people don't go to psychotherapy.
Knowledge and fear of psychotherapy (7)	Assesses participants' knowledge of psychotherapy and fears they experience about engaging in psychotherapy.	I would not see a psychotherapist because I'm afraid I won't be taken seriously.
Belief about inability to find a psychotherapist (3)	Assesses the degree to which beliefs about the difficulty of finding a qualified psychotherapist act as a barrier to seeking mental health services.	I would go to psychotherapy if I could find a psychotherapist who works with someone my age. (Reverse scored)
Belief that depressive symptoms are normal (3)	Assesses the extent to which participants believe that depression is normal for themselves and their peers.	I would not see a psychotherapist because I believe the way I feel is normal.
Insurance and payment concerns (5)	Assesses the degree to which money and insurance deter participants from seeking mental health services.	I would go to a psychotherapist but my insurance limits the number of psychotherapy visits. (Reverse scored)
Ageism (4)	Assesses beliefs about negative attitudes of mental health professionals to work with certain groups of people, such as older adults.	I would not see a psychotherapist because they think working with someone my age is a waste of time.
Concerns about psychotherapist's qualifications (6)	Assesses beliefs that psychotherapists are not specifically qualified to help participants with their problems.	I would not go to psychotherapy because a psychotherapist can't understand the problems of someone my age.
Physician referral (3)	Assesses the degree to which participants are hesitant to adhere to physician recommendations to see a psychotherapist.	I would see a psychotherapist if my physician referred me to one. (Reverse scored)
Transportation concerns (8)	Assesses the degree to which lack of transportation and lack of parking are deterrents in seeking mental health services.	I would not go to psychotherapy because it is difficult for me to find transportation.

Table 2. Mean scores on the BMHSS among younger and older adults.

Scale	Younger adults	Older adults	<i>F</i>	<i>p</i>	$\eta^2$
BMHSS total	136.51 (21.48)	130.97 (19.05)	4.81	0.03	0.03
Intrinsic barriers	12.67 (2.14)	11.91 (2.06)	6.44	0.01	0.04
Help seeking	2.65 (0.52)	2.56 (0.44)	2.41	0.15	0.01
Stigma	2.11 (0.65)	1.97 (0.59)	3.08	0.08	0.02
Knowledge and fear of psychotherapy	2.34 (0.63)	2.27 (0.52)	5.11	0.03	0.03
Belief about inability to find a psychotherapist	3.32 (0.80)	3.03 (0.83)	4.06	0.05	0.03
Belief that depressive symptoms are normal	2.52 (0.72)	2.41 (0.65)	1.86	0.16	0.01
Extrinsic barriers	11.95 (0.78)	11.61 (1.65)	4.54	0.04	0.03
Insurance and payment concerns	3.34 (0.77)	2.87 (0.63)	18.30	0.00	0.11
Ageism	1.81 (0.58)	1.87 (0.50)	0.03	0.88	0.00
Concerns about psychotherapist's qualifications	2.12 (0.57)	2.27 (0.53)	0.82	0.37	0.01
Physician referral	2.28 (0.63)	2.14 (0.59)	6.50	0.01	0.04
Transportation concerns	2.07 (0.58)	2.19 (0.49)	0.75	0.39	0.01

Table 3. Mean scores on the BMHSS among young-old and old-old adults.

Scale	Young-old	Old-old	<i>F</i>	<i>p</i>	$\eta^2$
BMHSS total	129.08 (21.38)	132.49 (16.48)	1.51	0.22	0.01
Intrinsic barriers	11.55 (2.27)	12.24 (1.79)	-0.21	0.06	0.05
Help seeking	2.54 (0.50)	2.55 (0.39)	0.22	0.64	0.00
Stigma	1.84 (0.65)	2.07 (0.51)	1.14	0.29	0.02
Knowledge and fear of psychotherapy	2.12 (0.59)	2.23 (0.44)	2.22	0.14	0.03
Belief about inability to find a psychotherapist	3.05 (0.80)	3.04 (0.88)	1.50	0.22	0.02
Belief that depressive symptoms are normal	2.25 (0.67)	2.53 (0.60)	6.04	0.02	0.07
Extrinsic barriers	11.51 (1.87)	11.65 (1.59)	0.92	0.34	0.01
Insurance and payment concerns	2.86 (0.73)	2.88 (0.53)	2.48	0.12	0.03
Ageism	1.8 (0.56)	1.89 (0.40)	0.03	0.86	0.00
Concerns about psychotherapist's qualifications	2.33 (0.57)	2.20 (0.48)	1.70	0.20	0.02
Physician referral	2.06 (0.60)	2.20 (0.57)	0.87	0.35	0.01
Transportation concerns	2.09 (0.53)	2.27 (0.45)	6.60	0.01	0.08

( $M = 3.28$ ,  $SD = 0.78$ ) reporting that finding a psychotherapist is a significantly greater barrier than men ( $M = 2.93$ ,  $SD = 0.78$ ), with a small effect size ( $\eta^2 = 0.04$ ).

### Comparisons of young-old with old-old

To further compare age-differences on the BMHSS among sub-groups of older adults, the older adult sample was divided into two groups: young-old (60–74 years old;  $n = 40$ ) and old-old (75–90 years old,  $n = 42$ ). A series of two-way ANOVAs was conducted to examine the effects of age group (young-old compared to old-old) and gender as well as the interactions of age group and gender on the BMHSS total score, intrinsic barriers score, extrinsic barriers score, and the 10 subscales.

#### Age by gender interactions

No significant interactions were found.

#### Age effects

Statistically significant main effects were found for age group on two subscales: belief that depressive symptoms are normal subscale,  $F(1, 77) = 5.80$ ,  $p = 0.021$  and

transportation concerns subscale,  $F(1, 75) = 6.60$ ,  $p = 0.01$ . Both of these effects were in the same direction with old-old participants perceiving significantly greater barriers than young-old participants (see Table 3 for means and effect sizes).

#### Gender effects

Statistically significant main effects for gender were found on two scales: belief about inability to find a psychotherapist subscale,  $F(1, 76) = 5.75$ ,  $p = 0.02$ , with women ( $M = 3.71$ ,  $SD = 0.81$ ) reporting a belief about the inability to find a psychotherapist to be a significantly greater barrier than men ( $M = 2.80$ ,  $SD = 0.85$ ) with a moderate effect size ( $\eta^2 = 0.07$ ) and insurance and payment concerns subscale,  $F(1, 75) = 9.00$ ,  $p = 0.004$ , with women ( $M = 2.99$ ,  $SD = 0.61$ ) reporting insurance and payment concerns to be a significantly greater barrier than men ( $M = 2.63$ ,  $SD = 0.62$ ) with a moderate to large effect ( $\eta^2 = 0.11$ ).

#### Ranking of BMHSS scales

To further facilitate the comparisons of barriers among younger adults and older adults, the scales of the BMHSS were rank ordered separately for each age

Table 4. Rank order of BMHSS subscales among younger and older adults.

Scale	Younger adults	Scale	Older adults
Insurance and payment concerns	3.34 (0.77)	Belief about inability to find a psychotherapist	3.03 (0.83)
Belief about inability to find a psychotherapist	3.32 (0.80)	Insurance and payment concerns	2.87 (0.63)
Help seeking	2.65 (0.52)	Help seeking	2.56 (0.44)
Belief that depressive symptoms are normal	2.52 (0.72)	Belief that depressive symptoms are normal	2.41 (0.65)
Knowledge and fear of psychotherapy	2.34 (0.63)	Concerns about psychotherapist's qualifications	2.27 (0.53)
Physician referral	2.28 (0.63)	Knowledge and fear of psychotherapy	2.27 (0.52)
Concerns about psychotherapist's qualifications	2.12 (0.57)	Transportation concerns	2.19 (0.49)
Stigma	2.11 (0.65)	Physician referral	2.14 (0.59)
Transportation concerns	2.07 (0.58)	Stigma	1.97 (0.59)
Ageism	1.81 (0.58)	Ageism	1.87 (0.50)

Table 5. Simple correlations between years of education and BMHSS total score and subscales by age group.

Subscale	Younger		Older		Total	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
BMHSS total	0.10	0.40	-0.31	0.01	-0.16	0.05
Intrinsic barriers	0.11	0.36	-0.31	0.01	-0.15	0.06
Help seeking	0.21	0.08	-0.15	0.18	-0.01	0.89
Stigma	0.12	0.30	-0.33	0.00	-0.16	0.05
Knowledge and fear of psychotherapy	0.02	0.90	-0.30	0.01	-0.18	0.02
Belief about inability to find psychotherapist	-0.30	0.01	-0.15	0.18	-0.20	0.01
Belief that depressive symptoms are normal	0.25	0.03	-0.20	0.07	-0.03	0.70
Extrinsic barriers	0.12	0.36	-0.27	-0.27	0.13	0.10
Insurance and payment concerns	-0.09	0.44	-0.14	0.19	-0.13	0.11
Ageism	0.16	0.19	-0.36	0.00	-0.17	0.04
Concerns about psychotherapist's qualifications	0.22	0.06	-0.10	0.36	0.02	0.80
Physician referral	0.21	0.08	-0.14	0.19	-0.02	0.85
Transportation concerns	-0.10	0.41	-0.17	0.13	-0.12	0.12

group (Table 4). Spearman's correlation for ranked data revealed strong significant similarities ( $r=0.90$ ,  $p=0.000$ ). As can be seen in the table, the top four rankings for both groups were highly similar. The rankings indicated that concerns about costs associated with mental health services and about how to locate an appropriate clinician were the most pressing concerns for both age groups. Concerns about the psychotherapist's qualifications was ranked as the fifth greatest barrier for older adults whereas concerns about the psychotherapist's qualifications was the seventh ranked barrier among younger adults. Transportation concerns was the seventh ranked barrier among older adults whereas it was the ninth ranked barrier among younger adults. Interestingly, stigma received the second lowest ranking for older adults and the third lowest for younger adults suggesting that many other factors are perceived as more important barriers than stigmatization. Finally, ageism was ranked as the lowest barrier for both age groups.

#### ***Additional analysis: Impact of ethnicity and relationship between education and barriers***

To explore the potentially confounding impact of ethnicity on the results, simple correlations were computed between ethnicity and the 10 subscales of the BMHSS. Results showed that ethnicity was significantly correlated with only one subscale (insurance and payment concerns,  $r=0.28$ ,  $p=0.00$ ). Due to its minimal impact, ethnicity was not included in any of the analyses.

Finally, simple correlations were computed to determine the extent of relationships between years of education and the BMHSS total score, intrinsic scale, extrinsic scale, and the 10 subscales (Table 5). Among the full sample, significant correlations were found on 3 of 10 subscales as well as the extrinsic scale and the BMHSS total score. The correlations for the subscales ranged from  $-0.01$  (help seeking subscale) to  $-0.20$  (belief about inability to find a psychotherapist). All correlations were in the negative direction with the

exception of the concerns about psychotherapist's qualifications subscale and overall the magnitudes were small. Among younger adults, significant correlations were found for 2 of the 10 subscales. Among older adults, significant correlations were found for 3 of the 10 subscales as well as the intrinsic scale and the BMHSS total score. In general, increased education was related to decreased perception of barriers toward seeking mental health services, although, in general, the effect sizes were small.

## Discussion

Although barriers to mental health services have been highlighted individually in a plethora of research studies, numerous barriers typically have not been examined in relationship to each other. As such, a potentially important aspect of this study was that a host of barriers to receiving mental health services were examined among younger and older adults using a newly created measure. Whereas it is generally believed that stigma and help seeking behaviors are possible barriers for older adults seeking mental health services, few studies have actually compared older and younger adults on these variables (Robb et al., 2003; Segal et al., 2005). Instead, research has focused on the percentage of older adults highlighting stigma as a concern (Currin et al., 1998; Lundervold & Young, 1992; Waxman et al., 1984) or the researchers explored help seeking attitudes of older adults to identify potential barriers (Hadas & Midlarsky, 2000). The present results are congruent with Segal et al. (2005) who did not find an age difference in stigma when younger adults and older adults were compared directly and with Mackenzie et al. (2006) who found older adults had more favorable views toward seeking mental health services than younger adults. Furthermore, the rank order of barriers from highest to lowest in the present study revealed that stigma appeared near the bottom for the younger adult group and older adult group, suggesting that relative to other barriers, stigma is perceived as being among the least influential. This provides further evidence that when younger and older adults are directly compared on the degree to which stigma acts as a barrier to seeking mental health services, they report similar trends: stigma is not a significant barrier and there are no age differences.

The cross-sectional results revealed that younger adults consistently reported experiencing more barriers that prevent them from seeking mental health services than older adults. Additionally, the only significant gender main effects indicated that men perceive stigma to be a greater barrier to seeking treatment than women, whereas women perceived finding a psychotherapist to be a greater barrier than men. Furthermore, when interactions were detected (extrinsic barriers and physician referral) younger men endorsed the highest perception of barriers. It is a common finding that men are less likely than women to seek mental health

services (Hauenstein et al., 2006; Mackenzie et al., 2006; Rhodes et al., 2002) and the present results shed light on some specific barriers among men (e.g., stigma) that may prevent men from greater use of mental health services. This finding comports with research documenting that negative attitudes related to psychological openness among Canadian men contributes to their underutilization of mental health services (Mackenzie et al., 2006).

The rank ordering of barrier scales pointed out that concerns about insurance coverage and the cost of services were among the most prominent for younger and older adults alike. Fortunately, with recent legislation in the United States phasing out the discriminatory co-pay policies for mental health services in the Medicare system, we anticipate that financial barriers will decrease in the near future, at least among older adults. It should be noted that concerns about insurance coverage and the associated costs of mental health treatment may more accurately reflect a *perception* of poor coverage and high costs. In fact, many older adults have Medicare and a supplemental insurance (which covers the portion that Medicare does not cover, at least in most cases) and many college students have access to low-cost mental health services at their schools' counseling center. The cross-sectional finding among the young-old and old-old that women reported concerns with payment and insurance to be a greater barrier than men is not surprising. Indeed, epidemiological data have consistently demonstrated that older women are among the poorest of the poor, experiencing high rates of poverty. In fact, women 75 years old and older have the highest proportions of individuals living 150% below the poverty level (U.S. Census Bureau, 2008). The current study provides evidence that older women are reluctant to engage in mental health services because of worries regarding payment.

The cross-sectional results revealed that two specific barriers were greater for the old-old adults compared to the young-old adults. We found that the belief that symptoms of depression are normal is a relatively greater barrier among old-old adults, a finding which comports with previous research (Sarkisian et al., 2003). Educational efforts directed at the old-old group aimed to correct the mistaken belief that depression is to be expected in later life appear to be needed. The old-old group also reported that transportation to mental health providers is a relatively greater obstacle to treatment compared to the young-old. This finding is also understandable in that individuals in the old-old group tend to be more frail, with multiple physical complications that restrict or prevent them from being able to drive (Carr, Flood, Steger-May, Schechtman, & Binder, 2006). According to Foley, Heimovitz, Guralnik, and Brock (2002), more than one third of individuals 70 years old or older do not drive (82% of males and 55% of females) suggesting that free or low-cost transportation services are sorely needed for this age group. Whereas it may be feasible for a family



member or social service to provide transportation to the occasional medical appointment, the transportation demands of weekly psychotherapy may be too great for many of these individuals.

The rank ordering of barriers in the current study supports previous research (Qualls, 1998) that concerns about psychotherapist's qualifications is a meaningful barrier to seeking mental health services among older adults. Indeed, this subscale was ranked as the fifth greatest barrier for older adults (although there were no age differences in the cross-sectional results). This result suggests that older adults may be concerned that there are not enough psychotherapists interested in their age group and specifically trained and qualified to work with their age group. In fact, this view is correct because there are too few specifically trained clinical geropsychologists to meet the needs of the burgeoning older adult population now and in the projected future (Qualls et al., 2002). Thoughtful analyses of this issue (e.g., Barrick et al., 1995; Kaplan, Adamek, & Martin, 2001; Lee, Volans, & Gregory, 2003; Robb et al., 2002) have suggested some possible reasons for the lack of professionals interested in working with older adults including pejorative negative attitudes about older adults, financial disincentives to work with older adults, and lack of confidence about assessing and treating the problems of older adults. Specialized programs and professional training opportunities in geropsychology and geriatric psychiatry simply must be expanded to meet the mental health needs of the older population.

A strength of this study was that numerous barriers were examined among younger and older adults. However, the current study has several notable limitations. First, many of the older adult participants in this study were relatively healthy, active, and highly educated individuals, most of whom transported themselves to the research facility. The older sample was also comprised solely of Caucasian individuals from an urban city in the Western United States. Therefore, our findings may not generalize to more physically frail, less independent, less educated, more rural, and more ethnically diverse older adults. In our sample, higher levels of education were moderately related to lower levels of stigma, at least among the older adults. Thus, future studies should continue to explore the nature of stigmatized beliefs among samples of younger and older adults with lower levels of formal education. Additionally, results yielded from scales with generally lower alphas (belief that depressive symptoms are normal; physician referral) should be interpreted with caution and future work on the BMHSS should strive to improve the reliability of these subscales. Future studies should explore the psychometrics of the BHMSS among diverse groups of younger and older adults, including rural older adults who are known to have especially high mental health needs and especially low utilization rates (e.g., Hauenstein et al., 2006; Maiden & Peterson, 2002). Future research should also focus on the continued

development of the BMHSS, which preliminarily, appears to be a promising measure of barriers to seeking mental health services. Further studies are needed to evaluate specifically the test-retest reliability of the measure and the convergent validity of the measure. Finally, future studies should include factor analyses to determine the number of unique dimensions underlying the items of the BMHSS.

Psychological disorders (e.g., depression, substance abuse, personality disorders) are likely related to mental health utilization patterns and this topic should also be explored in future studies of the BMHSS using diverse groups of clinical samples. Barriers perceived by underserved groups, including ethnic minorities, who are known to underutilize mental health services, should also be investigated. Indeed, Kearney, Draper, and Barón (2005) documented in their review that ethnic minorities underutilize mental health services and they identified possible barriers for this phenomena, many of which could be formally measured by the BMHSS (e.g., lack of confidence about psychotherapist's abilities; negative stigma associated with mental health treatment). The utilization of mental health services by ethnic minority groups is further constricted when considering ethnic minority older adults (Weisman et al., 2005) who are less likely to access these services because of both ethnicity and age. Applying the BMHSS to marginalized groups, including diverse groups of older adults, will likely enhance our understanding of their perceived barriers to mental health services.

This study represents the first step toward assessing the reliability and preliminary validity of the BMHSS. This measure has the potential to increase researchers' and practitioners' understanding of why groups do not seek mental health services. Identifying these barriers is the necessary step toward making much needed mental health services more accessible to those in need. The present study, although preliminary, suggests that further research on the BMHSS seems warranted.

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