Attitudinal Differences towards Mental Health Services between Younger and Older New Zealand Adults

Shelley A. James and Heather Buttle, *Massey University, New Zealand*

This study aimed to explore attitudinal differences between young and older New Zealand adults to seeking professional mental health services, including effects of previous help, and the types of service preferred. A questionnaire which included the Inventory of Attitudes towards Seeking Mental Health Services (IASMHS), together with questions regarding previous help, and preferred services for mental health needs, was administered to 125 participants aged 27-91 residing in the north Auckland area. Older adults were higher in help-seeking propensity (HSP) but less psychologically open (PO) than their younger counterparts. In older adults only, previous help contributed positively towards PO, while increased satisfaction with previous help correlated with increased indifference to stigma (IS). Older adults had a preference for physicians for mental health issues, followed by friends, God, clergy and psychiatrists. Attitudes towards help-seeking were generally favourable in older adults, but their lower PO and preference for service provider may inhibit their use of professional psychological services. General practitioners and clergy need to be provided with resources which enable them to refer older adults appropriately.

Mental and substance use disorders are among the most burdensome [diseases] in the world, and this burden is projected to increase (Oakley Browne, Wells, & Scott, 2006, p. 36). So say the findings of the World Health Organisation (WHO) Global Burden of Disease Study (Murray and Lopez 1996b, 1996c, as cited in Oakley Browne et al., 2006). The lifetime prevalence of mental illness in North America is about 30% (Kessler et al., 2005), over 20% in Australia (Ciarrochi & Deane, 2001), and almost 40% in New Zealand (Oakley Browne et al., 2006). Hence it is of great concern that the mental health needs of individuals worldwide are being served inadequately.

Despite the abundance of literature indicating that professional mental health services can be beneficial in decreasing distress (Ciarrochi & Deane, 2001), approximately 65-80% of adults who meet the criteria for a mental disorder in North America (Kessler et al., 2005; Mackenzie, Gekoski, & Knox, 2006), 62% in Australia (Ciarrochi & Deane, 2001), and 61% in New Zealand (Oakley Browne et al., 2006), do not receive any form of healthcare for the disorder. A New Zealand mental health survey (Oakley Browne et al., 2006) found that 39.5% of the New Zealand population would predictably develop a mental disorder at some time during their lives, while 20.7% had met the criteria for a mental disorder in the 12 months prior to the study. Of those receiving some form of healthcare, only 16.4% received care from a professional mental health specialist, while 28.3% consulted a general medical practitioner and 6.9% used a complementary or alternative medical (CAM) service. The overall treatment rates, regardless of service type, were comparable to those of other developed North American and European countries as reported in the World Mental Health Survey Initiative (Demyttenaere et al., 2004, as cited in Oakley Browne et al., 2006). This raises the serious question as to why such a large percentage of people do not utilise professional mental health services.

Research indicates that there are many factors which may influence whether a person decides to seek help from a mental health professional. Some of those mentioned in the literature include gender, age, availability of social supports, social acceptability, financial resources, educational level, type of psychological problem, previous experience of professional help, fear, dispositional qualities, approach and avoidance conflict, limited knowledge of mental health and services, and culture (Abe-Kim, Takeuchi, & Hwang, 2002; Al-Rowaie, 2001; Carlton & Deane, 2000; Ciarrochi & Deane, 2001; Ciarrochi, Wilson, Deane, & Rickwood, 2003; Deane, Skogstad, & Williams, 1999; Healy, 1998; Karlin & Duffy, 2004; Kushner & Sher, 1989; Mackenzie, 2001; Mackenzie et al., 2006; Morrison & Downey, 2000; Neha, 2004; Ortega & Alegria, 2002; Robb, Haley, Becker, Polivka, & Chwa, 2003; Williams, Skogstad, & Deane, 2001; Wu et al., 2001).

It has long been assumed that older adults are less receptive to professional mental health care because of adverse attitudes. Despite their mental health needs, mental health service usage by older adults is well below that of their younger counterparts, resulting in the

older adult population being substantially underserved by mental health services (see for example, Charney et al., 2003; de Vries & Smits, 2005; Dupree, Watson, & Schneider, 2005; Karlin & Duffy, 2004; Mackenzie et al., 2006; Mays, 2002; Robb et al., 2003; Rogers & Barusch, 2000; Wang et al., 2005). For example, it has been suggested that in older adults, actual rates of mental illness may be underestimated due to symptoms of illness going undetected or being mistaken for natural aging processes (Hsu, Moyle, Creedy, & Venturato, 2005).

As regards to age, older adults have a complex array of mental health needs which may derive from age-related factors such as the loss of partners and friends, deteriorating physical health and capabilities, loss of independence, reduced financial stability, and retirement which may bring a loss of personal identity (Alpass & Neville, 2003). Mood disorders, such as depression and bipolar disorder, are among the most commonly found mental health issues in the elderly (Charney et al., 2003). Other mental health issues frequently found include anxiety disorders, substance abuse, cognitive impairment and suicidal behaviours (Charney et al., 2003; Hsu et al., 2005; Karlin & Duffy, 2004; Robb et al., 2003), with the risk of developing a mental disorder greater amongst those in institutional settings (American Psychological Association, 1993, as cited in Hsu et al., 2005).

Given the considerable underutilisation of professional mental health services by older adults, it is surprising that few studies have investigated the attitudes of the elderly to mental health resources. However, one study in the United States (Robb et al., 2003) found that while older adults were less experienced and less knowledgeable about psychological services, their attitudes were generally favourable toward these services. Moreover, the type of resource used for mental health issues tended to differ between younger and older adults, with the older adults more likely to utilise primary care physicians and clergy.

Mackenzie et al. (2006) reported similar results in a Canadian study that focused on older male participants, with older adults exhibiting more positive attitudes than younger adults. The subscales of the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004) showed Help-seeking Propensity (HSP) to be higher in older participants who were better educated and Psychological Openness (PO) to be greater for females with higher education. There was a significant interaction for PO between age and marital status, showing a positive influence of age for single participants. Age was not a significant predictor on the third subscale, Indifference to Stigma (IS). As with Robb et al., Mackenzie et al. (2006) found that older adults were most likely to seek psychological help from their general practitioner. Conversely, a study in the United States by Billingsley (1999) found little difference between younger and older adults in help-seeking attitudes, with both showing a slightly positive result. However, these studies were all based in North America so results may not generalise to the older New Zealand population.

Within New Zealand only four studies have investigated attitudes toward seeking professional psychological help. In a study of a non-clinical university student sample Deane and Todd (1996) found attitudes toward help-seeking to significantly predict help-seeking intentions for both emotional problems and suicidal thoughts. These results were replicated in a sample of 221 high school students, however in this study, help-seeking intentions were inversely related to suicidal ideation (Carlton & Deane, 2000). The remaining two studies have looked at the attitudes of male prisoners toward seeking professional psychological help (Deane et al., 1999; Williams et al., 2001). Both studies found that favourable attitudes were related to higher help-seeking intentions. While psychological distress was related to positive attitudes to help-seeking, stigma, as in previous studies, was related to more negative attitudes. Previous experience of psychological help also influenced attitudes in that a prior positive experience with a psychological professional increased help-seeking intentions.

However, none of these New Zealand based studies have focused on investigating the attitudes of older and younger adults. Yet New Zealand, like many other Western countries affected by the post-war baby-boom, has an aging population. Between 1956 and 1996 the number of people age 65 and over doubled, rising from 9.1% of the population to 11.7%. When the first of the baby-boomer generation reaches aged 65 in 2010, it is anticipated that the percentage growth of people in New Zealand age 65 and over will rise dramatically, reaching approximately 25% of the total population by 2051 (Statistics New Zealand, 2006). Indeed, the elderly are the fastest growing sector of the New Zealand population.

In respect of the increasing numbers of older adults, the New Zealand Ministry of Health has, over the last decade, specified as one of it's aims to increase "responsiveness to people with mental health problems, and… [to co-ordinate] … care provision across the health and social service sectors… [T]o improve mental health service provision for specific groups in the community, especially… older people… [and to] recognise the importance of reducing the stigma and discrimination associated with mental illness that may act as barriers to people accessing appropriate care for recovery" (Ministry of Health, as cited in Oakley Browne et al., 2006, p 141).

In light of this, the purpose of this study was to compare the help-seeking attitudes of younger and older New Zealand adults towards professional mental health services. It was hypothesised that help-seeking attitudes would be similar to those found in the North American studies, with older adults being less psychologically open, but showing fairly positive attitudes towards help-seeking. The type of support people actually use when they are in emotional distress has been little studied, so a further area of interest in this study was to investigate which methods of support people would consider using when faced with a distressing, emotional or mental health problem, their preferences for support service, and whether these supports differ between younger and older New Zealand adults. Results from previous North American studies indicate that older adults have a preference for primary care physicians and clergy for mental health needs, so

it was hypothesised that these findings would be reflected in this study and that CAM services would be utilised more by younger adults.

Although the focus of this study is on the attitudes and preferences of older adults compared to younger adults, other factors have been found to be important including the effect of previous help on help-seeking attitudes and differences in gender. Regarding previous help, there have been mixed results with some studies showing a positive effect (Al-Rowaie, 2001; Carlton & Deane, 2000; Smith et al., 2004) and others showing an effect only when satisfaction with prior help was regarded favourably (Deane et al., 1999). In this study we also included previous help and level of satisfaction with previous help. Studies exploring gender differences in seeking professional mental help have indicated that females are generally more positive in their attitudes toward help-seeking (Al-Rowaie, 2001; Chandra & Minkovitz, 2006; Healy, 1998; Kushner & Sher, 1989; Mackenzie et al., 2006; Smith, Peck, & McGovern, 2004; Yeh, 2002). Hence, gender was also initially included as a variable.

Method

Participants

The non-probability convenience sample consisted of 138 adults from the north Auckland area, predominantly the North Shore and Orewa. Thirteen respondents were excluded from the study as they were either aged under 25 or did not complete the entire questionnaire. Of the remaining 125 participants, the mean age was 56.5 (= 16.49) with ages ranging from 27 to 91. As older adults were the focus of this study, participants were grouped into age bands of younger (25-64) and older (65+). 65 was selected as the cut-off point as per Robb et al. (2003). In the younger age group, of the 76 participants, 25 were male and 51 female. Of the 49 participants in the older age group, 22 were male and 27 were female. The majority of the participants (89.6%) classified themselves as New Zealand of European descent with the remaining being Mäori (0.8%), Pacific Islander (0.8%), Asian (1.6%) or Other (7.2%). High school was the highest level of education for 49.6% of participants, while 22.4% had attended a technical institute, 26.4% had completed a university qualification and 1.6% did not state their educational level. All participants gave informed consent and the study was conducted in accordance with Massey University Human Ethics Committee guidelines.

Measures

A questionnaire containing 3 sections and taking approximately 10-15 minutes to complete, was used to collect the data. The cover page of the questionnaire outlined the purpose of the study and stressed the anonymity of participants and confidentiality of the data, as well as the voluntary nature of participation. Massey University Human Ethics Committee low-risk information was provided on this page. Section 1 comprised the IASMHS (Mackenzie et al., 2004). Participants were also asked in Section 1 to indicate whether they had ever received help from a mental health professional and to rate their satisfaction with the help received on a 5-point Likert scale (0 = Extremely dissatisfied, 1 = Somewhat dissatisfied, 2 = Neither dissatisfied nor satisfied, 3 = Somewhat satisfied, 4 = Extremely satisfied). Section 2 consisted of a list of 42 help sources grouped into 7 broader categories: Professional Mental Health (4), Medical/Community (10), Cultural (2), Social (5), Religious/Spiritual (5), Alternative/Complementary (11), and Other (5). Participants were asked to indicate which services they would consider using when seeking help for a distressing emotional or mental health problem, as well as which service would be their first and second preference. Section 3 contained eight demographic questions which included: gender, age, residential details (suburb/city, number of people in the household, relationship to those in the household, and type of dwelling), ethnicity, and highest level of educational achievement.

The IASMHS (Mackenzie et al., 2004) is a modified version of Fischer and Turner's (1970) Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS). Confirmatory factor analysis was used to identify three factors: Psychological openness (PO), Help-seeking Propensity (HSP), and Indifference to Stigma (IS). The IASMHS includes 24 items (8 items for each subscale) which are rated on a 5-point scale: 0 = disagree; 1 = somewhat disagree; 2 = undecided; 3 = somewhat agree; and 4 = agree. Examples of these items as they relate to the three subscales are: "There are experiences in my life I would not discuss with anyone." (PO); "If I were to experience psychological problems, I could get professional help if I wanted to." (HSP); and "Having been mentally ill carries with it a burden of shame." (IS). The 3 subscales of the IASMHS (PO, HSP and IS) have internal consistency coefficients ranging from 0.76 to 0.82 (Mackenzie et al., 2006). The overall internal consistency coefficient is 0.87. Test-retest reliability is high for the PO (r = 0.86) and IS (r = 0.91) subscales, and moderate for HSP (r = 0.64). At the suggestion of Mackenzie, the definition example of "professional" was modified to exclude family physicians, as these professionals are not considered to be specialists in mental health issues. The definition example used was "psychologists, psychiatrists, psychotherapists and counsellors".

Procedure & Design

Prospective participants were approached by the researcher or a research assistant outside three shopping centres in north Auckland (Orewa, Browns Bay and Albany). These areas were selected as they include a large number of elderly residents and a mix of socio-economic groups. Those who agreed to participate were given the questionnaire which took approximately 10-15 minutes to complete. Chairs were provided to avoid a long standing period for elderly participants. Most participants completed the questionnaire independently, however a small number requested assistance due to eyesight difficulties. These participants were read the questions and responded verbally while a research assistant filled in the questionnaire. No identifying information was recorded and the anonymity of the data collected was emphasised. Once the questionnaire had been completed it was returned to a research assistant. A small number of volunteers (10) from a seniors group on the North Shore also participated, completing the questionnaire at one of their meetings.

Factors analysed in this study were within-subject factors of attitudes, previous help, satisfaction with previous help and choice of mental health service provider, in relation to the between-subject factor of age group.

Results

Attitudes

The overall mean score for participants was 68.56 (*SD* = 12.34) out of a possible score of 96 on the IASMHS, with the mean scores for the older and younger adults being 66.59 (*SD* = 12.88) and 69.74 (*SD* = 11.95), respectively. These scores indicate a moderately positive attitude toward seeking mental health services in both the older and younger participants. Table 1 shows the mean scores for the total IASMHS and each of the subscales.

A 3 x 2 x 2 mixed factor ANOVA (within-subjects factor of subscale (PO, IS and HSP), between-subjects factor of age group, and between-subjects factor of gender) indicated that the main effect of gender was non-significant. As gender was not a key focus of this study it is not discussed further. Hence, data were then collapsed across gender and a 3 x 2 mixed factor ANOVA (subscale and age group) was calculated. While the main effect of age group was non-significant, the main effect of subscale was significant ($F(2,216) = 33.68$, $p < .05$). The subscale of HSP yielded the highest score (*M* = 25.56) and PO the lowest (*M* = 19.58), however, these need to be interpreted in view of a significant interaction between age and subscale ($F(2,216) = 14.93$, $p < .05$).

In order to establish where the significant differences occurred, Bonferroni adjusted post-hoc comparisons were calculated for each of the subscales. Difference in PO between age groups was statistically significant ($t(116) = 4.09$, $p < .05$), with older adults being less psychologically open (*M* = 17.07, *SD* = 6.84) than younger adults (*M* = 21.96, *SD* = 5.96). Help-seeking Propensity also revealed a statistically significant difference between age groups ($t(117) = –2.31$, $p < .05$). Older adults were more likely to indicate they would seek professional help for a psychological problem (*M* = 26.6, *SD* = 5.64) than younger adults (*M* = 24.26, *SD* = 5.19). No significant differences were found in results for either the IS subscale or the total score on the IASMHS between the older (*M* = 22.40, *SD* = 6.37; *M* = 66.59, *SD* = 12.88, respectively) and younger adults (*M* = 23.93, *SD* = 5.96; *M* = 69.74, *SD* = 11.95, respectively).

Given the significant differences between age groups on the subscales of PO and HSP, Pearson r correlations were conducted to explore the strength of relationship between age and each of the subscales. The relationship between PO and age showed a moderate negative correlation ($r(114) = –.40$, $p < .05$), while the relationship between HSP and age showed a small, though significant, positive correlation ($r(116) = .26$, $p < .05$). The correlation between IS and age was not significant.

Previous Professional Help

Of the 116 participants who completed this section, 43 stated they had received prior help from a mental health professional. An independent t-test revealed a significant difference ($t(114) = 2.48$, $p < .05$) between the mean age of those having received professional help (*M* = 51.69, *SD* = 13.97) compared to those who had not used a professional psychological service previously (*M* = 59.43, *SD* = 17.26), indicating that younger adults were more likely to have consulted a psychological professional than those in the older age group. A further ANOVA was conducted with the between-subjects factor of previous help added to the factors of age group and subscale (see Table 2). As was shown in the original ANOVA, there was a significant interaction of subscale and age group ($F(2, 210) = 9.15$, $p < .05$), as described previously. The main effect of previous help was significant ($F(2, 105) = 4.12$, $p < .05$), with those who had previous help scoring higher (*M* =24.45 compared to *M* = 22.01). However, the factor of previous help interacted with subscale ($F(4, 210) = 2.69$, $p < .05$), with post-hoc tests revealing that only the subscale of PO was affected by previous help. Hence, PO was higher for those who had previous help (*M* =23.16 compared to *M* = 18.06). Furthermore, previous help interacted with age group ($F(1,105) = 5.12$, $p < .05$), with the younger age group scoring similarly regardless of previous help (*M* = 23.51 with help, compared to *M* = 23.00 without help),

Table 1 *Mean Scores by Age Group for the IASMHS and Each of the Subscales*

	n		***M***		***SD***	
Scale	**Y[a]**	**O[b]**	**Y[a]**	**O[b]**	**Y[a]**	**O[b]**
PO	73	45	21.96	17.07	5.96	6.84
IS	72	43	23.93	22.40	5.96	6.37
HSP	74	45	24.26	26.60	5.19	5.64
Total IASMHS	69	41	69.74	66.59	11.95	12.88

[a] Y = Younger adults aged 25-64.

[b] O = Older adults aged 65+.

but the older group scoring higher if they had received previous help (M = 25.39 with help, compared to M = 21.02 without help). No other main effects or interactions were significant.

Satisfaction with Previous Professional Help

Those participants who had received previous professional help (n = 41) rated their satisfaction with treatment on a scale of 0 to 4, with those rating their previous treatment more positively, less affected by possible stigma related to seeking psychological help (see Table 3). There was a small positive correlation (Pearson r) between satisfaction and IS scores ($r(43) = .31$, $p < .05$) but no significant correlation between satisfaction and either PO or HSP. Total IASMHS score also correlated moderately positively with satisfaction ($r(40) = .40$, $p < .05$).

An ANOVA between age group, satisfaction and subscale scores, revealed no main effects of, or interactions between, these factors. These results must be interpreted cautiously however, as the number of younger adults who rated their satisfaction unfavourably was small, as was the number of older adults who had received prior professional help.

Choice of Service Providers/ Source of help

Support services which would be considered for mental health issues by younger and older adults are shown in Table 4 by support service group. Chi-square analyses on each of the types of service groups showed no significant differences between younger and older age groups except in the "Other Services" group ($\chi^2(1, n = 125) = 6.57$, $p < .01$) . The younger adults were more likely to choose "Other Services" (24%) than the older adults (6%) .

Analyses were then carried out on individual services within the groups (see Table 5). While both older and younger adults seemed equally likely to seek Professional Mental Health services, the term used for the mental health professionals made a difference to their choice, with psychologists and psychotherapists being a less likely choice for older adults ($\chi^2(1, n = 125) = 9.18$, $p < .01$; $x^2(1, n = 125) = 7.06$, $p < .01$; respectively), and yet the choice of psychiatrists and counsellors was similar for both groups.

Within the Medical services there were no significant differences between age groups and both groups had a high willingness to consult a general practitioner. Community services were considered equally unlikely by both older and younger adults with the exception of social workers ($\chi^2(1, n = 125) = 9.35$, $p < .01$). While younger adults may consider consulting with a social worker (17%), older adults would not consider this option (0%).

Both age groups considered Social supports to be of particular use when faced with a mental health problem, although differences in choice of social support were evident. Friends were considered more often by younger adults ($\chi^2(1, n = 125) = 7.01$, $p < .01$), as were the participants' partners and spouses ($\chi^2(1, n = 125) = 9.50$, $p < .01$). Work colleagues were also less likely to be considered by older participants ($\chi^2(1, n = 125) = 7.73$, $p < .01$).

The Religious/Spiritual services showed significant differences in utilisation by older and younger adults. Religious leaders were more popular with the older age group (31% compared to 17%) although this preference was not statistically significant. As with the predilection for seeking the assistance of clergy for a mental health problem, choosing to seek support from God was considered more likely by older adults than by the younger age group ($\chi^2(1, n = 125) = 7.01$, $p < .01$).

While numbers for most of the CAM and Other services were too small for meaningful analysis, telephone support services were more likely to be chosen by younger (22%) rather than older (4%) adults ($\chi^2(1, n = 125) = 7.73$, $p < .01$).

Preferred Service Providers

First and second preferences for services

Table 2 *Mean Scores by Age Group and Previous Help for the IASMHS Subscales*

Scale	**Age Group**[a]	**Previous Help**[b]	***n***	***M***	***SD***
PO	Y	0	37	20.73	5.93
		1	30	23.27	5.52
	O	0	30	15.23	6.77
		1	11	22.18	4.51
IS	Y	0	37	24.65	6.03
		1	30	22.63	5.57
	O	0	30	21.27	5.60
		1	11	25.55	7.59
HSP	Y	0	37	23.62	5.26
		1	30	24.63	5.23
	O	0	30	26.57	6.08
		1	11	28.46	3.70

[a] Y = Younger adults aged 25-64, O = Older adults aged 65+.

[b] 0 = No previous psychological help, 1 = Previous psychological help.

Table 3 *Mean Scores by Age Group and Satisfaction with Previous Help for the IASMHS Subscales*

Scale	Satisfaction[a]	*n*		*M*		*SD*	
		Y[b]	O[b]	Y[b]	O[b]	Y[b]	O[b]
PO	0	2	0	16.50	–	3.54	–
	1	4	3	22.25	22.00	5.56	2.00
	2	5	1	23.20	21.00	6.02	–
	3	10	2	24.30	26.00	3.56	7.07
	4	8	5	24.63	21.00	7.44	5.20
IS	0	2	0	17.00	–	9.90	–
	1	4	3	20.50	21.00	5.92	12.77
	2	5	1	25.60	22.00	2.61	–
	3	10	2	23.40	25.50	4.79	3.54
	4	8	5	22.38	29.00	6.89	5.10
HSP	0	2	0	21.50	–	.071	–
	1	4	3	21.75	25.67	6.29	3.51
	2	5	1	24.60	29.00	2.88	–
	3	10	2	25.90	26.00	4.89	5.66
	4	8	5	25.63	31.00	6.99	1.73

Note that "– " indicates that no data were recorded.

[a] 0 = Extremely dissatisfied, 1 = Somewhat dissatisfied, 2 = Neither dissatisfied nor satisfied, 3 = Somewhat satisfied , 4 = Extremely satisfied.

[b] Y = Younger adults aged 25-64, O = Older adults aged 65+.

were provided by 62 younger and 40 older adults. As can be seen in Figure 1, when first and second choices were combined, the most popular choices for younger adults were general practitioner (55%), partner/spouse (32%) and friend (21%). Older adults had a clear preference for general practitioner (65%), followed by friend (20%), then equally for God (18%), religious leader (18%), and psychiatrist (18%). Older adults were more likely than younger adults to choose God as their first preference, while younger adults were more likely than their older counterparts to choose their partner/spouse first. Chi-square analysis revealed significant differences between age group and partner/spouse ($\chi^2(1, n = 102) = 3.98$, $p < .01$) as first preference for choice of help with a psychological problem. God as preferred choice could not be analysed due to a low expected count for the younger adults' cell. There were no other significant differences in preferred choices between the older and younger age groups.

Discussion

The purpose of this study was to compare both attitudinal differences towards mental health services and mental health service preference differences, between younger and older adults in order to ascertain whether attitudes contributed to the underutilisation of professional mental health services by the growing population of older New Zealand adults.

Attitudes

The results showed no marked differences between younger and older adults in respect of the overall IASMHS scores, a result similar to that seen in the study by Mackenzie et al. (2006), with both age groups showing reasonably favourable attitudes. However, differences were observed on the subscale scores of PO and HSP, with a clear association being shown between age and these subscales. Older adults were considerably more positive in their attitudes towards help-seeking than their younger counterparts. Conversely, they were notably less open about psychological matters.

Paradoxically, although older adults were attitudinally more positive toward seeking help, service utilisation by this age group in New Zealand is still below that of younger adults. Robb et al. (2003) found a similar discrepancy between willingness to seek help and actual utilisation of professional services by older adults in the United States. This incongruity in the study by Robb et al. may have been a result of the inclusion of physicians in the choice of services. In the current study, it may be that the participants also included general practitioners in their definition of "professional help" when completing the inventory. This is despite the fact that the original IASMHS definition of "professional help" was modified in the current questionnaire, as suggested by Mackenzie et al. (2004), so that it did not include general practitioners in the example. It did not, however, specifically exclude them. Given the older age group's proclivity to consult a

Table 4 *Service Groups/Source of Help Considered by Age Groups*

Service	Age Group[a]	*N*	Would Consider Using *(n)*	Pearson Chi-Square		
				χ^2	*df*	*Sig.*
Professional Mental Health	Y	76	65	1.99	1	.16
	O	49	37			
Medical	Y	79	68	1.56	1	.21
	O	49	40			
Community	Y	76	27	2.41	1	.12
	O	49	11			
Cultural	Y	79	4	Expected count too low for analysis		
	O	49	2			
Social	Y	76	68	1.56	1	.21
	O	49	40			
Religious/Spiritual	Y	79	24	3.81	1	.05
	O	49	24			
Alternative/Complementary	Y	76	30	3.00	1	.08
	O	49	12			
Other	Y	79	18	6.57	1	.010**
	O	49	3			

[a] Y = Younger adults aged 25-64, O = Older adults aged 65+.

** $p \leq .01$.

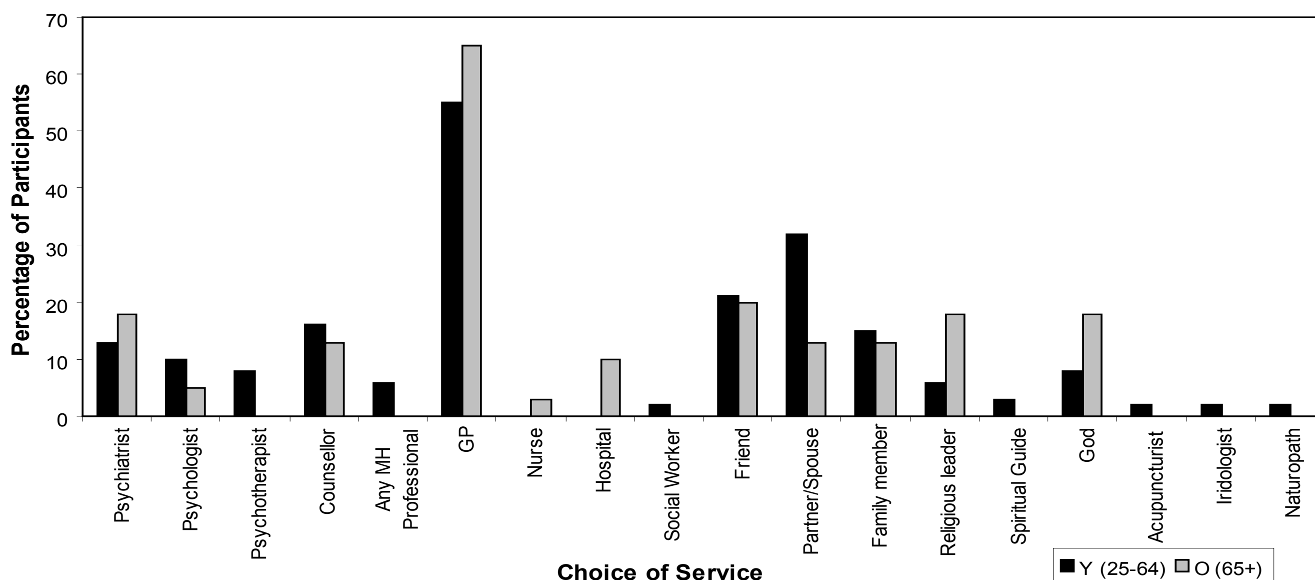
Table 5 *Percentage of Age Groups Considering Utilising Individual Services/Sources of Help*

Y[a] (%)	**O[a] (%)**	**Services**	**Y[a] (%)**	**O[a] (%)**	**Services**
		Professional Mental Health			**Religious/Spiritual**
41	41	Psychiatrist	17	31	Religious leader
45	18	Psychologist	5	6	Spiritual guide
28	5	Psychotherapist	14	35	God
61	51	Counsellor	3	0	Psychic/Astrologer
		Medical	5	2	Other Religious/Spiritual
89	78	G.P.			**CAM[b]**
16	6	Nurse	17	2	Acupuncturist
12	14	Hospital	11	2	Aromatherapist
12	6	Pharmacist	20	12	Homeopath
		Community	8	2	Hypnotherapist
17	0	Social worker	9	0	Iridologist
12	2	Citizens Advice Bureau	4	0	Light and colour therapist
9	6	Lawyer	4	0	Magnetic healer
3	8	Age Concern	16	8	Massage therapist
21	10	Support group	22	14	Naturopath
		Cultural	4	0	Rebirthing therapist
4	4	Kaumatua/Cultural elder	11	0	Other CAM
1	0	Other Cultural			**Other**
		Social	0	0	Agony aunt
72	49	Friend	0	0	Internet chat room
72	45	Partner/spouse	22	4	Telephone support
53	51	Family member	17	2	Complete stranger
22	4	Work colleague			
1	4	Caregiver			

[a] Y = Younger adults aged 25-64, O = Older adults aged 65+.

[b] CAM = Complementary or Alternative Medical Service.

Figure1



physician for a mental health issue, this may have affected the results.

It is interesting to note that stigma did not feature as a significant difference in the comparative analyses. The common assumption that older adults are more prone to concerns regarding stigma was not supported by the data. Although stigma has not been extensively studied specifically in relation to older adults, this result is similar to that reported by Mackenzie et al. (2006), who found that stigma did not play a significant role in deterring older adults from seeking professional mental health services. In summary, these results add to an increasing understanding of mental health attitudes in the older population and for the first time provide information about older adults' attitudes in New Zealand.

Previous Professional Help

As with the US study by Robb et al. (2003), younger adults were more likely to have previously consulted a mental health professional. However, the effect of previous professional help on attitudes was only noteworthy in relation to the PO subscale. Older adults scored higher if they had experienced previous professional help but this effect was not observed in younger adults. It may be that the higher psychological openness of the younger adults encourages them to seek help when it is needed, regardless of previous help, and therefore any difference is neutralised. For older adults who have been induced to consult a professional, increased psychological openness may be the consequence. This result differs from that of Deane et al. (1999) where prior help had no effect on help-seeking attitudes. However, this might be explained by the fact that the participants in their study were predominantly younger in age (M = 32.33 years) and were from a distinct population (e.g. prisoners). While Carlton and Deane (2000) found a positive effect of previous help on help-seeking attitudes of teenagers, both of these studies related prior help to overall help-seeking attitudes, not to the specific subscale of PO.

Satisfaction with Previous Professional Help

Increased satisfaction with prior help correlated overall with the IASMHS. The subscales showed that increased satisfaction slightly decreased the perceived stigma relating to seeking professional help. Level of satisfaction had no effect on HSP or PO. Again, this conflicts with the findings of Deane et al. (1999) where a positive perception of prior help was related to improved help-seeking attitudes in younger adults. This discrepancy may exist because, as with the results for prior help, satisfaction ratings were analysed in relation to overall help-seeking attitudes by Deane et al., rather than by subscales. Also, the number of participants in the current study who had both experienced and rated prior help, were small (n = 41 compared to n = 73 in the study by Deane et al.). Further investigation which includes a larger sample size of those having experienced prior professional help, may clarify these effects.

Choice of Service Providers/ Source of help

The choice of services which would be considered for a mental health problem generally did not differ between younger and older adults when these services were grouped into the general categories of Professional Mental Health, Medical, Community, Cultural, Social, Religious/ Spiritual, CAM, and Other. However, when separated into individual services, there were marked differences. Within the Professional Mental Health services both age groups were equally likely to choose a psychiatrist, whereas the older participants were less likely to choose the assistance of a psychologist or psychotherapist. It is possible that, like many people, the participants were not aware of the differences between the education and roles of these professionals and therefore selected the one that was most familiar to them. Alternatively, older people may have a

higher regard for a medically trained professional, which was evident in their partiality for general practitioners. Counsellors were also a popular choice for both age groups. This category of service provider, however, should perhaps have been placed in the Medical or Community services section as many counsellors are lay trained and do not necessarily fit into the definition of a Professional Mental Health service provider.

Unlike the study by Robb et al. (2003), where older, but not younger, adults were most likely to consult a physician, both age groups were just as likely to indicate a willingness to seek the assistance of a general practitioner for mental health issues. In fact, this option was the first choice for both age groups.

When compared with younger adults, the older group were not in favour of consulting a social worker or telephone support service, but showed a stronger inclination toward clergy and God, results which are in accordance with the findings of Robb et al. (2003). Social supports were considered equally as helpful by both age groups, however younger adults were more likely to seek out friends or their partner/spouse. These results could be reflective of the loss of friends and partners by those of advanced age. Similarly, work colleagues were more favoured by the younger group, which is indicative of a retired older population. While there was no significant difference between age groups in usage of CAM practitioners when grouped together, individual services were rated more highly by younger adults.

Preferred Service Providers/ Sources of help

As stated earlier, when considering preferences for psychological help, both groups were most in favour of seeking the help of a physician. Younger adults preferred to then turn to their spouse followed by their friends, whereas older adults turned to friends, then God, clergy and psychiatrists.

It was of interest to note that older adults chose God as a first choice, or not at all. This may reflect the religious belief that God is the ultimate source of assistance. It may also be indicative of the belief of some older people that mental health problems denote a neglect of religious prescriptions, and that personal difficulties are challenges sent by God to be surmounted on one's own (de Vries & Smits, 2005).

Limitations

Before discussing implications, certain limitations of this study need to be considered. First is the consideration of the representativeness of participant sample. Caution needs to be used in generalising findings from a convenience sample, as (1) potential participants may have had different motives for declining or accepting to participate, (2) the participants were from one regional area (North Auckland), and (3) the numbers were limited to 125 participants, with 49 in the older adult group. However, despite this caution, the results have provided statistically meaningful differences that are generally consistent with similar research that has typically come from North American samples. Another limitation of this study was the chunking of the participants into broad age bands so that any differences within the older and younger groups were not investigated. It would be of interest in future studies to explore whether there is any diversity across the full spectrum of age ranges rather than imposing an arbitrary division at age 65.

A further limitation was that many of the participants expressed an uncertainty about the differences between the various Professional Mental Health services listed. This may well have affected the results and possibly given an inaccurate portrayal of the preference for a specific profession. A replication of this study could either specify the differences between the choices, or could include an option of "Any professional listed" so that those who are unsure of the speciality of each profession may still indicate their preference for a trained professional mental health service provider. Future research which investigates people's beliefs about the roles of the different mental health professionals would be of interest.

Implications

These results have implications for the promotion of mental health services to the older population of New Zealand. While older adults have indicated a willingness to seek professional help, they perhaps lack knowledge about psychological services which may be of benefit. Efforts to encourage professional service utilisation amongst older adults should concentrate not on stigma alone, but should widen the focus to include education about the services which are available. In view of the finding that older adults have a preference for general practitioners and clergy, these service providers need to be educated as to the benefits of professional help for older adults and encouraged to refer clients to the apposite service. For example, clergy need to be provided with the resources to enable them to refer parishioners to an appropriate professional. It would be beneficial to institute a service where professionals (non mental health) who frequently face clients with mental health problems could liaise with mental health professionals to obtain information and resources.

Conclusion

The results of this study were consistent with the findings of similar studies in the United States (Robb et al., 2003) and Canada (Mackenzie et al., 2006) in that attitudes do not appear to be a major barrier for older New Zealand adults seeking psychological help. It is encouraging to find that older adults have a generally positive attitude towards seeking professional mental health services and that stigma pertaining to these services is not ubiquitous amongst the older population. Their preference for medical and clerical services needs to be appreciated and supported by educating these providers as to the benefits of referral to specialist professional services. The promotion of psycho-education amongst the older age group may exploit their willingness to seek help, thereby increasing the utilisation of professional services by this underserved sector of society.

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