

OLDER ADULTS' EXPERIENCES SEEKING PSYCHOLOGICAL CARE

Navigating Pathways to Care: Exploring Older Adults' Experiences Seeking Psychological Care
Using the Network Episode Model-II

by

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Dedications

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Abstract

Within the next 20 years, mental health problems are projected to be the leading cause of disability in Canada. Given that one in four Canadians is expected to be over the age of 65 by 2036, older adults' mental health problems are a growing public health concern, especially because the rate of mental health service use is particularly low among this age group. Although there have been several decades of mental health research, it is still not well understood why older adults are not accessing treatment. A possible explanation for this is that identifying reasons for poor access alone does not capture the multifaceted, complex nature of individuals' experiences with mental health problems and their paths into treatment. To address this gap in the literature, this study explored older adults' experiences seeking psychological care and the factors that influence this dynamic process using the Network Episode Model-II (NEM-II; Pescosolido & Boyer, 2010; Pescosolido et al., 2013). To achieve this objective I conducted 15 individual semi-structured interviews with adults 60 years of age and older, who were receiving outpatient psychological services from a hospital in Winnipeg, Manitoba. Findings from this study suggest that participants' background (social content), social support network, and the treatment system influence, and are influenced by, participants' illness careers. Factors that delayed participants' help-seeking included: a lack of support, "inappropriate" referrals or advice from treatment professionals, and a lack of knowledge among older adults about mental health and treatment options. This research has implications for researchers, clinicians, and public policy initiatives aimed at enhancing older adults' access to psychological care.

Keywords: mental health, older adults, service utilization, illness career, Network-episode model

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Navigating Pathways to Care: Exploring Older Adults' Experiences Seeking Psychological Care
Using the Network Episode Model-II

Mental health problems¹ are expected to be the leading cause of disability in Canada within the next 20 years (Canadian Institute for Health Information, 2011). As a result, mental health has emerged as a national priority (Kirby & Keon, 2006), culminating in the release of Canada's first national mental health strategy (Mental Health Commission of Canada, 2012). Given that one in four Canadians is expected to be over the age of 65 by 2036 (Statistics Canada, 2011), older adults' mental health problems are a growing public health concern. Unfortunately, older adults are unlikely to seek professional help for mental health problems that can be severe, complex, and chronic (Byers, Arean, & Yaffe, 2012; Mackenzie, Reynolds, Cairney, Streiner, & Sareen, 2012). Although there have been several decades of mental health research, it is still not well understood why older adults are not accessing treatment. A possible explanation for this is that identifying reasons for poor access alone does not capture the multifaceted, complex nature of individuals' experiences with mental health problems and the ways in which their experiences, opinions and beliefs influence their paths into treatment. To address this gap in the literature, this study explored older adults' experiences seeking psychological care and the factors that influence this dynamic process.

Prevalence of Older Adults' Mental Health Problems

Evidence from large-scale community surveys in Canada, the United States, and Australia suggest that mental health problems become less prevalent with age (Henderson, 2002; Mackenzie, Pagura, & Sareen, 2010; Reynolds, Pietrzak, El-Gabalawy, Mackenzie, & Sareen,

¹ For the purpose of this study, *mental health problems* are defined as an impairment in emotional, psychological, and social well-being, which can present as a diagnosable clinical condition such as depression, anxiety, and psychosis, or less severe symptoms of emotional distress (Mental Health Foundation, 2016).

2015; Streiner, Cairney, & Veldhuizen, 2006), which is consistent with several models of healthy aging. The Selective Optimization with Compensation theory suggests that despite the losses of abilities and skills in old age, successful aging can and does occur when people (1) select goals and goal priorities, (2) optimize resources that facilitate their goals, and (3) compensate for losses by creatively using alternative means to achieve their goals, despite limited capacities (Baltes & Baltes, 1990). Even when older adults experience mental health problems, compensation and optimization are strongly associated with successful aging (Ouwehand, de Ridder, & Bensing, 2007). In line with this, the Socio-emotional Selectivity Theory (SST) suggests that emotional functioning also typically improves with age (Carstensen & Mikels, 2005). According to this theory, older adults prioritize emotion-focused goals while younger adults are motivated to pursue goals related to expanding knowledge and seeking information (Carstensen et al., 1999). This theory suggests that improved mental health in later life is due to both prioritizing emotion-focused goals and the *positivity effect*, in which older adults tend to focus on positive information and process negative information less deeply than younger adults (Carstensen, 2006). Therefore, findings from these large-scale surveys may reflect the resiliency of older adults such that, with aging, comes experience, wisdom, and improved mental health.

Despite the evidence of general improvements in mental health with age, there is some suggestion that mental health problems are under-recognized and under-reported in late life (Streiner et al., 2006). True prevalence rates of mental health problems among older adults are likely to be underestimated in large-scale community surveys due to a number of confounding factors including cognitive decline, comorbid physical health problems, misattribution of mental health symptoms to physical health problems, and insufficient diagnostic scales and criteria for

older adults (Streiner et al., 2006). For example, epidemiological data from Canada suggests that approximately 14% of adults aged 50 years and older experienced a mental disorder or substance dependence within the past year. However, this percentage underestimates the true prevalence of mental disorders because a limited number of anxiety disorders were measured in the Canadian Community Health Survey (Mosier et al., 2010). The confounding factors previously mentioned not only obscure prevalence estimates, they also make it increasingly difficult for primary care physicians and other health care specialists to recognize, diagnose, and effectively treat older adults presenting with complex and co-morbid mental and physical health problems (El-Gabalawy, Mackenzie, Pietrzak, & Sareen, 2014; El-Gabalawy, Mackenzie, Shooshtari, & Sareen, 2011). Despite the existence of confounding factors, it is important to note that these factors do not likely account for, nor explain away, the trend of lower rates of mental health problems among older adults, which is consistent with models of healthy aging (Baltes & Baltes, 1990; Carstensen & Mikels, 2005; Streiner et al., 2006).

Although older adults are less likely to experience mental health problems than their younger counterparts, there are unfortunately, a number of older adults who do have clinically significant mental health problems, including depression and anxiety (Crowley, 2011; Mosier et al., 2010; Streiner et al., 2006). Results from a population-based study of older adults in Manitoba indicated that approximately 20% of men and 29% of women had depression, anxiety, personality disorders, substance dependence, or schizophrenia during a five-year study period (Martens et al., 2007). Charles and Piazza's (2009) Strength and Vulnerability Integration (SAVI) model suggests that, although aging is associated with an increased ability to regulate emotions, when older adults cannot avoid negative experiences, they are prone to physical and psychological vulnerabilities (e.g., illness, loss of independence and social belonging, chronic

stressors, etc.). When older adults are vulnerable, age-related improvements in emotional regulation and affective well-being decrease, which increases their likelihood of experiencing emotional distress and mental health problems (Mackenzie & Reynolds, 2012). Moreover, older adults' experiences with mental health problems can be complex due to the high likelihood of comorbid mental and physical disorders. A study by Bartels and Smyer (2002) found that approximately half of older adults who meet criteria for depression also meet criteria for an anxiety disorder. A Canadian population-based study exploring comorbid anxiety disorders among common physical health conditions in older adults found that physical health problems are associated with an increased risk of developing an anxiety disorder (El-Gabalawy et al., 2011; El-Gabalawy et al., 2014). This comorbidity was found to be associated with poorer self-reported health than physical health problems or anxiety alone. Additionally, older adults with comorbid mental and physical health problems experience greater disability in comparison to older adults with physical health problems (Bartels & Naslund, 2013). What is particularly alarming is that, despite having significant and complex mental health problems, multiple studies clearly show that older adults have especially low rates of mental health service use (e.g., Cairney, Corna, & Streiner, 2010; Karlin, Duffy, & Gleaves, 2008; Mackenzie et al., 2010; Mackenzie et al., 2012).

Older Adults and Help-seeking

Epidemiological data from Canada revealed that mental health consultations with primary care physicians and other health professionals decrease with age (Byers et al., 2012; Mosier et al., 2010), leaving older adults particularly vulnerable to receiving improper care. Previous research indicates that older adults are approximately three times less likely to report utilizing mental health resources in the past year, when compared to young adults (Crabb & Hunsley,

2006; Karlin et al., 2008). Similar findings were reported in the United States, suggesting that approximately half of older adults with a recognized mental disorder do not seek or receive mental health resources (Bartels & Drake, 2005; George, Blazer, Winfield-Laird, Leaf, & Fischbach, 1988; Mackenzie et al., 2010). Researchers have also shown that older male adults are significantly less likely to seek help in comparison with their female counterparts (Cox, 2014; Mansfield, Syzdek, Green, & Addis, 2008). For older adults who have received formal health care services for their mental health problems, as many as 80% reported receiving treatment from their primary care physician (Bogner, De Vries, Maulik, & Unützer, 2009; Cairney et al., 2010; Han, Gfroerer, Colpe, Barker, & Colliver, 2011; Klap, Unroe, & Unützer, 2003; Lippens & Mackenzie, 2011; Nyunt, Chiam, Kua, & Ng, 2009; Prévile et al., 2009). Unfortunately, the demands present in a busy primary care clinic make it challenging to provide comprehensive and effective health care to older adults. Perhaps as a result, older adults with mental health problems are more likely to receive inadequate or inappropriate treatment in comparison to young adults with mental health problems (Bartels & Drake, 2005; Druss, Bradford, Rosenheck, Radford, & Krumholz, 2001).

Barriers to Accessing Care

A number of individual and systemic barriers to older adults' use of mental health service have been investigated (Mackenzie et al., 2010; Pepin, Segal, & Coolidge, 2009). Previous researchers have identified a combination of individual factors preventing older adults from seeking help, including; a limited perceived need for care (Karlin et al., 2008; Mackenzie et al., 2010); a desire to handle problems on their own (Mackenzie et al., 2010; Wetherell et al., 2004); financial concerns (Pepin et al., 2009; Robb, Chen, & Haley, 2002); and a lack of mental health literacy (Gum, Iser, & Petkus, 2010; Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Lee,

Lytle, Yang, & Lum, 2010; Tieu, Konnert, & Wang, 2010; Wetherell et al., 2009), including a lack of knowledge about where and from whom to seek mental health services from (Mackenzie et al., 2010; Pepin et al., 2009). A qualitative study exploring older adults' help-seeking for depression found that a limited perceived need for formal care was a barrier to participants seeking health services for depression. Individuals in their study felt that the responsibility for combating depression was an internal, individual task and that seeking external support was secondary (Lawrence et al., 2006). Additionally, a study, in which 15 primary care practitioners and 20 patients were interviewed regarding their views on the causes and management of late life depression, found that there were elements of poor mental health literacy among all participants. For example, both practitioners and patients viewed depression as a consequence of social and contextual issues. Moreover, participants from this study stated that depression experienced by elderly patients was "understandable" and "justifiable" (Burroughs et al., 2006). Furthermore, a lack of knowledge regarding mental health service utilization was a commonly cited problem reported in a qualitative study by Ghesquiere (2013), exploring support seeking among older adults with complicated grief. The findings from Ghesquiere's (2013) study showed that individuals who sought specialized mental healthcare found the process challenging, as they were unsure about where to access resources.

Older adults do not only experience individual barriers to accessing mental health care; a number of systemic barriers have also been identified (Bartels & Drake, 2005; Fields, 2000; Pepin et al., 2009). Systemic barriers contributing to the underutilization of mental health services include a lack of economic resources, a shortage of accessible and age-appropriate services, and a scarcity of providers with expertise in the assessment and treatment of older adult mental health problems (Bartels & Drake, 2005; Fields, 2000). For example, despite older

adults' preference for psychological treatments for mental health problems (Gum et al., 2006; Wetherell et al., 2004), they are increasingly being prescribed psychotropic medications, including antidepressants and antipsychotics, despite the known risks associated with drug interactions (Schellander & Donnerer, 2009; Vieweg et al., 2009). In line with this, for the minority of older adults who do seek help for their mental health problems in the formal health care system, research has shown that primary care physicians are less inclined to refer geriatric patients to mental health professionals (Alvidrez & Areán, 2002). This may be due to the belief that psychological treatment is less effective for older adults compared to young adults (Mackenzie, Gekoski, & Knox, 1999) in addition to the lack of medical coverage or finances older adults have to utilize psychological resources (Pepin et al., 2009; Robb et al., 2002). With this in mind, older primary care patients are at an increased risk of being prescribed psychiatric medications and are less likely to be treated with psychotherapy in comparison to young adult patients with mental health treatment needs (Bartels & Drake, 2005; Bartels, Horn, Sharkey, & Levine, 1997). This is especially concerning given the strong support for the efficacy of psychological treatment for late life mood and anxiety disorders (Andreescu & Reynolds, 2011; Dailly & Bourin, 2008; Gonçalves & Byrne, 2012; Karlin & Fuller, 2007; Mohlman, 2004; Park & Unützer, 2011; Payman, 2011; Stanley & Beck, 2000; Wetherell et al., 2011).

Unfortunately, despite several decades of mental health research exploring barriers to accessing services, it is still not well understood why older adults are not accessing treatment (Bartels et al., 2004; Pescosolido, Boyer, & Medina, 2013). A possible explanation for this is that identifying reasons for poor access alone does not capture the multifaceted, complex nature of individuals' experiences with mental health problems and the ways in which their experiences, opinions and beliefs influence, and are influenced by, the paths they take. Additionally, the

various help-seeking and service-use models that have been developed (Andersen, 1995; Goldsmith, Jackson, & Hough, 1988; Maddux & DuCharme, 1997; Parsons, 1951; Strecher, Champion, & Rosenstock, 1997; Vogel, Wester, Larson, & Wade, 2006) are largely static and do not accurately reflect the dynamic nature of the help-seeking process (Pescosolido et al., 2013).

Service Utilization Models

Researchers have struggled for decades to create and conceptualize service use models that capture the dynamics concerning seeking care, and the individual, social, medical, and organizational characteristics that influence how individuals respond to their mental health problems (Pescosolido et al., 2013). Parsons (1951) developed the first model for understanding people's behaviour when they are sick. The Illness Career Model depicts stages that an individual transitions through as they evaluate their circumstances rationally and decide if they would proceed to enter the sick role or return to a normal role (Parsons, 1951). However, this model represents the ideal individual who is able to rationalize, in a state of poor mental health, how to proceed effectively into stages of treatment and recovery. In reality, this is not the case. From this initial conceptualization, well-developed but essentially static models of service utilization and help-seeking models were developed (Andersen, 1995; Goldsmith et al., 1988; Maddux & DuCharme, 1997; Strecher et al., 1997; Vogel et al., 2006) and began to dominate the mental health service use literature. The Health Belief Model (Strecher et al., 1997), the Theory of Planned Behaviour (Maddux & DuCharme, 1997), the Behavioural Model of Health Service Utilization (Andersen, 1995), and the Information Processing Model (Vogel et al., 2006) are similar in that they focus on a comprehensive set of variables that influence the use of health services and service outcomes. Nevertheless, key assumptions from these models focus primarily on factors that facilitate or inhibit access into the formal treatment system without

taking into considering the dynamics of how individuals respond to their mental health problems and engage in service utilization (Pescosolido et al., 2013).

The Cycle of Avoidance model (COA; Biddle, Donovan, Sharp, & Gunnell, 2007), added a unique contribution to the service use literature by providing a dynamic understanding of help-seeking behaviour, including individuals who had and had not sought help. Although this model extends previous static and deterministic models by offering a dynamic explanation of complex issues, it does not take into account how individuals' social networks influence their pathways to care. To progress, research must first take a step backward and re-evaluate what is known about the dynamics of mental health service use and where further theorizing and research are required (Pescosolido et al., 2013). Due to the complexity of the service utilization process, researchers have suggested the need for in-depth, qualitative assessment of factors that influence the utilization process over time (Gum et al., 2011).

Network-episode model. Unlike the previous models, the Network Episode Model-II (NEM-II; Pescosolido & Boyer, 2010; Pescosolido et al., 2013) has advanced more complex notions of mental health service use by focusing on a variety of pathways to service use and service configurations (for a visual model, see Figure 1). More specifically, this model views coping with a mental health problem as a social process that is managed through an individual's interactions with social networks in the community, the treatment system, and social service agencies. The NEM-II is unique in that it outlines how an individual's illness career can change over time, how it is shaped by earlier events, and it acknowledges that not everyone will travel the same path into the formal treatment system (Pescosolido et al., 2013). More recent versions of this model are available (NEM-III, NEM-III-R; Pescosolido, 2011) however; these versions have expanded into broad organizational models, potentially useful for social epidemiology as

well as health services research. In contrast, the NEM-II focuses specifically on mental health service utilization. Therefore, this earlier version of the model is ideally suited to understanding older adults' experiences seeking psychological care and the barriers and facilitators that influence their pathways to care. A quantitative study by Choi, Morrow-Howell, and Proctor (2006) utilized the NEM-II to identify patterns and configurations of service use, including all medical, psychiatric, and psychosocial services used by depressed older adults. Results indicated that factors in older adults' social network, a key element of the NEM-II, did not significantly contribute to service use configurations in their models. These findings suggest that not all aspects of the NEM-II may translate to older adults service utilization experiences for mental health problems. Another possible explanation may be that the quantitative methods used in this study were not able to capture the social complexity illustrated in the NEM-II. Additionally, due to the co-occurring physical health, mental health, and social changes that take place in later life, it is possible that the NEM-II may not have previously identified influencing factors unique to older adults' service use. Therefore, further theoretical exploration utilizing this model in a qualitative study with an older adult sample is warranted.

Research Objective

To address these limitations in the mental health treatment seeking literature, this study employed qualitative methods to explore older adults' experiences seeking psychological care for their mental health problems. More specifically, the objective of my study was to explore the dynamic and changing interactions between those suffering from mental health problems, their contexts, and their interactions with their social and treatment networks, using the NEM-II (Pescosolido & Boyer, 2010; Pescosolido et al., 2013).

Methods & Procedure

Research Strategy

I used interpretive description (Thorne, Kirkham, & MacDonald-Emes, 1997) to assess the objectives of this study. Interpretive description methodology seeks to articulate a meaningful and coherent description of the target phenomenon by incorporating thematic patterns (Thorne, Kirkham, & O'Flynn-Magee, 2008). The purpose is to identify themes and patterns within subjective perceptions and generate an interpretive description capable of informing clinical understanding (Thorne et al., 2008). Interpretive description is often used in small scale qualitative studies and requires samples to be theoretically and purposively generated, reflecting an understanding of expected and emerging variations within the phenomenon being studied. The techniques used for data collection and analysis can vary within interpretive descriptive methodology. For the purpose of this study, my research was guided by a constructivist worldview (Lincoln, Lynham, & Guba, 2011) and my data were analyzed using the framework analytic approach (Pope, Ziebland, & Mays, 2000).

Constructivist worldview. The constructivist worldview is based on the idea that individuals seek to understand the world in which they live and work by developing subjective meanings of their experiences (Lincoln et al., 2011). These meanings can vary from individual to individual, prompting researchers to rely as much as possible on the individual's view of the situation being studied (Creswell, 2014). With this in mind, my qualitative interview questions, assessing participants' experiences seeking psychological care for their mental health problems, were delivered in an open-ended format, which allowed participants to construct the meaning of their experiences. Additionally, social constructivists tend to focus on examining the process of interaction among individuals (Creswell, 2014). They believe subjective meaning is formed

through interactions with others and through historical and cultural norms that shape individuals' lives (Creswell, 2014). Therefore, social constructivists often address the process of interaction among individuals in their research. My study aligns strongly with this focus because coping with a mental health problem can be viewed as a social process that is managed through an individual's interactions with social networks in the community, the treatment system, and social service agencies (Pescosolido et al., 2013). Therefore, conducting this research within a constructivist worldview is fitting as opposed to conducting it within a postpositive, transformative, or pragmatic worldview, which would have been inappropriate for the purpose of this study (Creswell, 2014).

Framework analytic approach. Our research team (comprised of myself, Dr. Corey Mackenzie, Dr. Genevieve Thompson, and a volunteer from the Aging and Mental Health Laboratory) analyzed the transcribed interviews using a framework analytic approach (Pope et al., 2000; Ritchie & Spencer, 2002). This form of qualitative methodology offers clear, systematic directions for analyzing transcribed interviews. Additionally, this method allows researchers to identify themes originating from a priori theories as well as key concepts emerging from the interviews through inductive and deductive reasoning. Therefore, this method was appropriate because interview questions were based on a priori concepts derived from the NEM-II. However, this form of analysis is flexible in that it can incorporate and build on new concepts that emerge from the interviews. With an interest in mapping the collection of participants' experiences navigating pathways to psychological care, I kept the analysis closer to the described experiences of the participants as opposed to deriving higher order meaning from the data.

The framework analytic approach is comprised of six interconnected stages: (1) familiarization, (2) identification of a thematic framework, (3) indexing and sorting, (4)

reviewing data extracts, (5) data summary and display, and (6) abstraction and interpretation (Ritchie & Spencer, 2002). During the first stage, I familiarized myself with the data by listening to the interview recordings and reading the transcripts. I made note of key concepts and recurrent themes in each interview to gain an understanding of the full range of content, which lead to the second stage, identifying a thematic framework. My team and I then created the thematic framework by integrating the key themes and subthemes that appeared within and throughout the interviews. During this stage, I referred back to the mental health and help-seeking literature, to help guide and refine the themes and sub-themes emerging from the interviews. Specifically, I reviewed information regarding different forms of social support (Pescosolido et al., 2013) and coping (Endler, 1996) to help refine the themes into appropriate sub-themes. Subsequently, we began the third stage, indexing and sorting, by coding the transcripts according to the central themes and subthemes we identified. We applied the framework to each interview and we indexed each line of the transcripts according to the themes in the framework. Following this, we entered the fourth stage by refining the framework to minimize the number of original themes and reorganized the data into the most salient categories. In the fifth stage of analysis, I began charting each participant's transcript into a thematic chart (Excel spreadsheet) according to the index codes. This stage allows researchers to view the full range of data within each subtheme and compare across key themes and participants. During the final stage, abstraction and interpretation, my team and I interpreted the concepts to identify associations and patterns within the data and ensured the full range of participants' experiences had been described. During this process we continued to compare and contrast the emerging codes and themes in new interviews with previous interviews already established within the framework to ensure we had a thorough understanding of participants'

experiences.

Recruitment. I implemented purposive and theoretical sampling in my recruitment of participants. Purposive sampling allowed me to target older adults who were accessing mental health services from two geropsychologists at St. Boniface Hospital; and theoretical sampling allowed me to refine the interview protocol to further investigate emerging concepts based on framework analysis. Geropsychologists recruited participants from August 2015 to March 2016 and provided their clients, who met eligibility criteria, with an initial informed consent form (Appendix A). The geropsychologists approached a total of 25 clients ages 60 years and older regarding participation in this research, and $N=15$ clients (10 female and 5 male) agreed to participate, resulting in a response rate of 60%. Clients who were interested in participating in the study provided their contact information. I then contacted interested participants by telephone to further explain the study, to answer questions, and to schedule an interview time and location (Appendix B). Recruitment and analysis occurred simultaneously, in order to further examine emerging themes and subthemes and to make changes to the interview protocol. In line with the flexibility of framework analysis, we made modifications to the interview protocol, based on the identification of new concepts or themes and to help clarify and refine interview questions (Ritchie & Spencer, 2002). Ideally, additional participants would have completed interviews until the data reached *theoretical saturation*, indicated when no new themes or codes emerge from the interviews (Creswell, 2014). However, due to the limited time frame to complete my Master's thesis and the complexity of the NEM-II, I cannot ensure saturation. Nevertheless, I am confident of the robustness of the themes, as repetitive patterns were evident across participants' interviews.

Participants. Fifteen older adults, who were accessing mental health services from geropsychologists, participated in this research. To meet eligibility requirements, participants needed to be (a) 60 years of age or older, (b) fluent in English, and (c) cognitively intact with no obvious signs of cognitive impairment. Prior to distributing the initial informed consent forms to their clients, the geropsychologists screened participants to verify that they met the eligibility requirements. Participants received an honorarium of a \$10 Tim Hortons or Safeway gift card for taking part in this study.

Data Collection Procedure & Instruments

I collected various forms of data from August 2015 to March 2016, including 1) background questionnaires; 2) mental health across the lifespan graphs; 3) in-depth qualitative interviews; and 4) field notes. During analysis, I incorporated these sources of data, focusing primarily on the qualitative interviews in addition to relevant information from the three supplementary sources. For a complete list of the questions administered in the background questionnaires, an example of the mental health across the lifespan graph, and the interview protocol, please see Appendices C through F. Prior to commencing the interview, I reviewed the consent form (Appendix G) in detail with each participant and answered any questions they had. All of the participants agreed to proceed with the study by signing the consent form. Participants were provided a copy of the consent form and information regarding mental health resources in the community.

1) Background and health questionnaire. Prior to the interview, participants completed a background and health questionnaire measuring sociodemographic information, health information, social isolation and social connectedness, and level of distress. In the first section, participants provided the following sociodemographic information: age, gender, marital

status, level of education, occupation (previous or current), socioeconomic status, and race/ethnicity. The second set of questions measured participants' self-perceived health, the presence or absence of physical and/or mental disorders, and the amount of medication they take. Participants rated their health as excellent, very good, good, fair, or poor. They were also asked to rate their health on a scale from 1 (*poor*) to 10 (*excellent*). Participants completed two additional questions about the status of their current mental health treatment and how optimistic they were about the treatment they are receiving, with answer options ranging from 0 (*not optimistic at all*) to 10 (*very optimistic*).

In the third section, participants completed the abbreviated six-item version of the Lubben Social Network Scale (*LSNS-6*; Lubben et al., 2006), which measures social isolation and connectedness. The *LSNS-6* is a refinement of the *LSNS-10*, which was modified from the Berkman-Syme Social Network Index, and was specifically developed for use with an older adult sample (Lubben et al., 2006). This scale measures the frequency of contact with relatives and friends in addition to the closeness of these relationships and the ease of communicating with these individuals. A total score is obtained by summing the six items, with scores ranging from 0 to 30 and lower scores (e.g., clinical cut-off score of 12 or lower) indicating social isolation. Lubben and colleagues (2006) reported that the *LSNS-6* demonstrates high internal consistency for the total score ($\alpha = 0.83$ consistent across the three sites of the study), Family subscale (ranging from $\alpha = 0.84$ to $\alpha = 0.89$ across sites), and Friends subscale (ranging from $\alpha = 0.80$ to $\alpha = 0.82$ across sites).

Lastly, participants completed the Kessler Psychological Distress Scale-6 (*K6*; Kessler et al., 2002). The *K6* is a brief screening tool used to measure general psychological distress. Respondents were asked to rate how often within the past month they felt: "nervous?";

“hopeless?”; “restless or fidgety?”; “so depressed that nothing could cheer you up?”; “that everything was an effort?”; and “worthless?” Response options range on a 5-point rating scale from “all of the time” to “none of the time”. A total score from the six items indicated the level of distress a participant was experiencing, which can be categorized as being *low* (score of 0-7), *mild/moderate* (score of 8-12) and *high* (score 13-24) (Kessler et al., 2003, Wang et al., 2007).

Several studies have demonstrated that the *K6* possesses good psychometric properties with older adult samples (e.g., Furukawa, Kessler, Slade, & Andrews, 2003; Krynen, Osborne, Duck, Houkamau, & Sibley, 2013; Prochaska, Sung, Max, Shi, & Ong, 2012). Data obtained from the background and health questionnaire were used to describe the older adults participating in this study. Please refer to Appendix C for the specific set of questions.

2) Mental health across the lifespan graph. After participants completed the background and health questionnaire, they completed a graph, illustrating their mental health across their life span (see Appendix D). The graphs were then used as a tool to help participants reflect and discuss previous episodes in their lives when their mental health was poor, neutral, or excellent and what shaped their previous experiences.

3) Individual interview. In-depth interviews took approximately 60 minutes to complete and occurred in a location of the participant’s choice. Twelve participants completed the interview in their homes, two in the Aging and Mental Health research laboratory at the University of Manitoba, and one in a private room at the St Boniface hospital. By providing participants with multiple interview location options, I attempted to ensure they would be in a comfortable environment and I ensured that they would not have difficulty finding or arranging transportation to the interview location.

My research team and I developed interview questions based on the components in the NEM-II (Figure 1) and include the following concepts: (a) an individual's illness career may change over time, (b) current experiences are shaped by earlier events, (c) not everyone will travel the same path into the formal treatment system, and (d) individuals dealing with a mental health problem are influenced by their social networks, the treatment system, and social service agencies. The interview protocol began with the central, open-ended question, "What brings you in for treatment at St. Boniface Hospital?" Depending on the type of responses that emerged from this question, I explored more specific questions regarding the course of participants' mental health experiences, beliefs about causes of their mental health problems, past and current experience with various health care providers, treatment preferences, including benefits and drawbacks, and support received from participants' social network. Based on emerging concepts in the first two interviews, and with the goal of increasing clarity of the interview protocol, our research team made three revisions to the initial interview protocol. First, because religion played an important role in how the first few participants conceptualized and coped with their mental health problems, we added a question to explore whether people are religious and if so, how it has helped them with their mental health problem(s). Additionally, after the first two interviews it became apparent that participants' previous relationships with their parents, siblings, and friends played an important role in how supported participants felt in dealing with their previous mental health problems. To capture this, we added an open-ended question, assessing how supported participants felt by their social network in the past. Lastly, we removed several questions from the interview protocol because they did not gather new information from participants that they had not already discussed in answering previous questions. Please refer to

Appendix E to see the specific items in the interview protocol. Interviews were audio-recorded and professionally transcribed.

4) Field notes. Throughout data collection and analysis, I documented field notes during and after each interview. I gathered information on the participants' body language and observations I made of their home environment. Conducting observational fieldwork provided me with the opportunity to document how participants responded to interacting with me and gave me a better understanding of what was going on in participants' home lives. Throughout the analytic process, I incorporated my field notes by coding and including them in the development of the framework.

Rigor

Throughout data collection and analysis, I employed a number of procedures to address the rigor of the study's findings. First, I enlisted fellow researchers to aid in developing the interview protocol, in order to minimize bias in the interview questions. Additionally I recruited fellow researchers to read and code transcripts to increase inter-rater agreement and developed the thematic framework using a collaborative approach (Pope et al., 2000). Our research team discussed discrepancies in interpretation or coding until a consensus was reached among the group. Furthermore, I used deviant case analysis to ensure the framework and my overall interpretation explained all the data (Mays & Pope, 2000). Using this approach, I searched for data that appeared to contradict my interpretation and adjusted my analysis as needed. Additionally, I remained mindful of how my personal biases affected my interpretation of the data. Social constructivist researchers recognize that their personal backgrounds shape their interpretation of the data and thus must acknowledge how their biases affect the data analysis (Creswell, 2014). To aid in this process, I kept a reflexive journal, which helped me identify and

reflect on my personal background, beliefs, and biases (Creswell, 2014; Stake, 2010). For example, I am a young, female, middle-class, clinical psychology master's student. My clinical experience likely had a positive influence on the interview process, as my clinical training aided in my ability to build rapport with the participants, which may have helped them feel more comfortable to discuss personal and sensitive subjects. In addition to my clinical training relevant to this research, my close personal experience with older adults in my family is also relevant to the current study. From a young age, I developed close relationships with great grandparents, grandparents, and great aunts and uncles, some of whom were open about discussing their personal struggles with mental health. These close relationships, in addition to having an open dialogue regarding mental health, contributed to the compassion I have for people struggling with mental health problems. My belief that timely and accessible psychological services should be in place also likely influenced my interactions with the participants and my interpretation of the data. Finally, to address the rigor of this study, framework analysis provides a transparent audit trail, documenting how data moved from interview, to transcripts, to themes, to framework, thereby enhancing the credibility of the findings (Ritchie & Spencer, 2002).

Ethical Considerations

I obtained ethical approval through the University of Manitoba Psychology/Sociology Research Ethics Board and from the St. Boniface Hospital Research Review Committee. Participants provided written consent prior to their participation, and were given the option to withdraw from the study at any time during the research process (Appendix G). To protect participants' confidentiality, I changed their names and identifying information throughout the following section.

Findings

Sample Characteristics

Information on participants' sociodemographic characteristics, self-reported health status, level of distress, social isolation and loneliness scores, and treatment status are presented in Table 1. Participants were, on average, 72.3 years of age, 66.7% female, and 93.3% White (one identified as Filipino). The majority of participants were retired (86.7%) for an average of 13 years ($SD = 8.4$). Most of the participants (86.7%) were married/common law, and 13.3% were widowed. With respect to participants' health status, 46.7% rated their health as fair and 53.3% rated their health as good or excellent. Just under half of the sample (46.7%) reported that they were diagnosed with a mental health problem, including mood disorders (57.1%) and anxiety (42.9%). Participants exhibited a range of emotional distress, with 40% being classified as having low levels of distress on the *K6*, 33.3% having mild/moderate distress, and 26.7% having high distress. With regard to comorbid conditions, 66.7% reported that they had been diagnosed with at least one chronic disease, including arthritis, irritable bowel syndrome (IBS), fibromyalgia, diabetes, Parkinson's disease, hypothyroidism, and osteoporosis. Participants reported taking an average of 5.5 ($SD = 3.2$) medications daily, ranging from 0 to 11. The majority of participants (66.7%) reported that they have extended health coverage, however 10% of participants reported that their plan did not cover psychological services and 20% of participants were not sure whether their plan covered such services. On average, participants did not approach the clinical cut-off point for social isolation on either the total or subscale scores of the LSNS-6. However, several participants did endorse questions suggesting that they felt some degree of isolation from family and friends. More participants (26.8%) reported feeling isolated from friends than from family (6.7%). Participants were also asked to rate how optimistic they

were regarding their treatment at St. Boniface hospital on a scale from 0 (*Not optimistic at all*) to 10 (*Very optimistic*) and reported an average of 8.4 (SD = 1.4). With regards to participants' time spent in treatment, 20% stated that they just started seeing a psychologist, 53.3% were part way through, and 26.7% were nearing the end or recently completed treatment.

Thematic Framework: Older Adults Experiences Seeking Psychological Care

Participants' experiences seeking psychological care were identified by a number of themes, which were refined and categorized into the four broad sections of the NEM-II: the social content/episode base for the individual, the illness career, the social support system, and the treatment system (Figure 2). However, unlike the model, which incorporates the opinions and beliefs from the social support system and treatment system, the thematic framework focused solely on the perspective of the individual. In focusing on the perspective of the individual, we explored their experiences within their social content, illness career and their experiences interacting with their social support system and treatment system. Each of these themes will be discussed in detail below.

Theme 1: Social content/episode base for the individual. In line with the NEM-II, the first theme we identified was social content, which forms the base of the framework and sets the trajectory for participants' illness careers (Pescosolido, 1991). This theme contained three subthemes: 1) sociodemographic characteristics, 2) personal health background, and 3) nature of the mental health problem(s). It is important to note that the subthemes are not static; changing conditions in the illness career, social system and treatment system can influence outcomes in the social content/episode base for the individual and vice versa. These subthemes are described below.

Sociodemographic characteristics. Participants discussed three sociodemographic

characteristics that influenced their social content/episode base including, age/aging, income, and gender.

Age/Aging. Throughout the interviews, participants described several negative effects of aging that impacted their mental health, including: physical decline, cognitive decline, loss/bereavement, and existential crises. The majority of participants noted a decline in their physical health and discussed how they were sick more frequently, had a difficult time “bouncing back,” and described a lack of control over their physical symptoms. One woman said,

I struggle with incontinence and I can't really go anyplace anymore. I'm not good at night and you know it doesn't matter how many pads and things you wear, you don't wanna be losing control. I have absolutely no control over anything and so there's a change of lifestyle, you are anxious, you don't sleep (Participant 7).

Some participants noticed a decline in their cognitive abilities as well, and described the difficulty they experienced trying to distinguish between normal versus abnormal changes in cognition (e.g., “Taking into account that we both do forget, but then so do some friends our age, so there's another difficulty in distinguishing what the problem is” Participant 14). Participants also discussed the theme of loss in later life, including bereavement and a loss of independence. Many participants discussed the impact of losing family and friends as they aged. One woman said,

In a sense I've had a fairly privileged life and now I'm facing reality that things aren't always perfect and lives aren't always perfect and you know people do die and you have to suffer through that. Behind closed doors I feel like I'm still suffering the consequences of that cause we were married for almost 50 years” (Participant 2).

A few participants also described losing independence as they aged and the negative impact it has had on their self-esteem. In some cases, participants discussed first noticing their mental health declining when they began to lose their independence. When a man was asked how long he has been feeling depressed, he said, "I'd say it really started when I gave up my car driving, approaching two years. It happened shortly after that when I suddenly couldn't move about at my own discretion" (Participant 13). Lastly, one participant described experiencing an existential crisis and questioned the importance of his life, now that he was older and felt closer to death. He said,

I fear my own death. There are times where I think, would it ever be a relief if it did happen but I have to learn to accept that because that's like a cop-out away from problems. I need to feel an importance you know somewhere and to be listened to (Participant 12).

Income. Throughout the interviews, some participants discussed how their income and financial concerns were playing a significant role in their lives, causing them worry and stress, as they tried to calculate how much longer they could afford to live. When asked if there was anything else going on in her life that was making things more difficult, one woman said,

I guess it comes back a bit to finances. I do have financial fear...there's a bit of that going on and that sort of scares me. In recent years, I don't want to put it down to finances but they were becoming a problem for us. Before my husband died, I basically had to sell the house, which I did in fairly short order. They tell you not to do anything for the first year, well I moved out of my house in six months, I put my house on the market and sold everything and well, mostly gave it away and moved here (Participant 2).

In line with this, one third of participants reported that they did not have extended health coverage (i.e., a plan that covers services such as ambulance, physiotherapy, and may include other health services, such as psychotherapy, that not covered by Manitoba Health).

Additionally, some participants mentioned that they did not have money or insurance to pay for psychological treatment. The impact of income was also observed in field notes taken during the interview. Some participants' homes appeared to be falling apart and in need of repair, with bills and papers scattered on tables and the floor. In contrast, other participants' homes were clean, in pristine condition with beautiful pieces of art and sculptures positioned throughout their space. Additionally, some of these participants also mentioned that they had cleaners and lawn maintenance to help keep their homes looking nice, so finances appeared not to be a concern they had to worry about.

Gender. Although the research literature suggests important differences in help-seeking among men and women (Pattyn, Verhaeghe, & Bracke, 2015), gender did not emerge in a clear way in the data. For example, participants did not clearly articulate during the interview that their gender influenced their social context, however, subtle differences between females and males were observed in their mental health across the lifespan graphs. Female participants' illustrations of their mental health across the lifespan appeared to proportionately reflect the highs and lows in their mental health that were discussed during the interview. In contrast, male participants' illustrations of their mental health across the lifespan appeared to be positively skewed when compared to the content that they discussed during the interview. Additionally, given that women are overrepresented in mental health clinics (Slaunwhite, 2015; Wang et al., 2005), it is not surprising I recruited twice as many women ($n=10$) than men ($n=5$).

Personal health background. Three categories emerged under the personal health

background subtheme: history of mental health, history of support, and coping style.

History of mental health. Throughout the interview, participants described past experiences with their mental health and discussed periods of their life when their mental health worsened, improved, or stayed the same. The majority of participants (60%) reported episodes of poor mental health in the past and described an ongoing struggle to manage their mental health, which they illustrated in their mental health across the lifespan graph (see Figure 3). One woman, who would get physically sick when she was struggling to manage earlier episodes of her anxiety said,

I can remember instances where I would be in a stressful situation and just hardly be able to contain myself cause I was hurting and you know there's certain [times] that stick out in my mind that I can single out but that's going back a long time (Participant 2).

Similarly one woman said, when discussing her past experience with poor mental health and the difficulty she had:

A lot of [my] issues have not been dealt with; it was really a mixed bag of things that had not been dealt with over the years...between [the age of] 10 and 15...my mental health first took a dip because of the rape. And trying to get my mother to explain a little bit about, you know, I think she was trying to explain to me about periods but we never got very far with that because I didn't have my period yet. I kept at her and kept at her and finally she said well, these things happen in all families. Boys are boys. [I felt] like, give me a gun. And my sisters were very antagonistic towards me...there were some good times but then I got married and had a baby and the public health nurse at that time came to visit and she took one look at me and she says you look terrible, what is happening here...it's the first time anybody said anything to console me, and she got me in touch

with social services. But it was still a hard time and every once in awhile I'd feel pretty tough, down again... a few years later our son was killed...ten years after that, our [second] son died. It's been so difficult. My life has been turned upside down. It's always been tough. It's just tough. If I didn't have my faith, it would be iffy about what I might do to myself (Participant 3).

In contrast, some participants (40%) talked about how their mental health was fairly good for much of their adulthood with only recent struggles with mental health (see Figure 4). One man said,

I'm very up about my good life, very, very up. I mean I've had a lot of high points and my low points, they're almost high points too, I mean I, I look back at them and I have trouble remembering my low points (Participant 13).

When asked about her past experience with mental health, one woman said, "Well I guess it's been pretty good" and said that it was not until her husband was diagnosed with dementia that she noticed her mental health declining (e.g., "I just found the stress, watching him go downhill like that and knowing the options were fewer and fewer...that we were never gonna have a life together anymore, that it was over. I found that really painful, still do" (Participant 1).

History of support. Participants who had a history of mental health problems also described the kind of support they received in the past from friends, family, and the treatment system. Some participants described past accounts where they felt consistently supported by their friends and family during times of need. One man said, "Did I need help? Did I reach out? Sure I did. I can't recall to whom, I reached out to all of them one way or another, but they [family members] were all available to me" (Participant 13).

In contrast, some participants told stories that reflected a lack of support from friends and family during earlier periods of their life when they were struggling. One man said,

When I was young, I was only about 16, 17, I was still home and had an argument with my mother and I said I'm gonna go kill myself and I took the rifle and she said go ahead and do it. That time I was really depressed. My parents were pretty good parents, they did their job but they were happy to see you leave. We never got together as a family.

You know there didn't seem to be any love towards us like we never had birthday parties or Christmases or anything like that (Participant 8).

Similarly, participants described both negative and positive experiences with receiving support from mental health professional. One man said, "I went to see a psychologist for posttraumatic stress disorder and with all due respect it was a joke. He treated me as though I was now a total mentally decrepit person suffering the worst kind of stress" (Participant 14). In contrast, other participants who had previous treatment described this experience as positive, and in some cases, this experience influenced their decision to seek help in the future. Even when participants had a negative experience with a health professional, other positive experiences with the treatment system appeared to influence their decision to seek help again in the future. Despite the negative experience one participant had with receiving psychological treatment in the past, his more positive experience with a different psychologist is what ultimately influenced his decision to seek psychological service again (e.g., "It was because of my past experience with talking to a [different] psychologist before about retirement" Participant 14).

Coping style. This category refers to the general approach that participants have taken when dealing with mental health challenges. Three categories emerged under the coping style subtheme: problem-focused, emotion-focused, and avoidant. The majority of participants

discussed using a combination of all three coping strategies. Participants described using problem-focused coping when discussing ways in which they would change or modify the fundamental cause of the source of distress. For caregivers, this sometimes involved getting extra support to help take care of their spouse or parent, who they were caring for, or giving themselves a break and getting out of the house for short periods of time. “When I was feeling stressed out I would go to the shopping centre just to ease my mind. That’s why I keep myself occupied” (Participant 6). Other times, participants used emotion-focused coping strategies by changing their emotional response to the stress instead of changing the source of the stress. Participants described changing their emotional response to stressors through prayer, meditating, or relaxation techniques. One man said,

This may sound stupid but I’d go to bed and I’d cover my head up, make it dark in there. That sort of gave me comfort because I felt that nothing was going on with me, I could just stay in there and feel relaxed; I felt better. It was a safe spot I suppose. I still do that once in awhile (Participant 8).

Lastly, some participants talked about how they would avoid the source of distress by being in denial or minimizing the problem (e.g., “That was a life changer to kill somebody [in self defense] but it hasn’t affected me in my life” Participant 14).

Nature of mental health problem. When participants were describing the severity and course of their mental health problem(s), their responses varied. Some participants described their mental health problems as being quite severe and impacting other aspects of their lives (e.g., “[My depression] was very bad, I was very ill like I couldn’t eat, I would force myself to drink and it was very tough” Participant 9). In contrast, some participants described their struggles with mental health as more manageable (e.g., “I wouldn’t say it’s really severe cause it

doesn't stop me from doing things" Participant 2). When participants were asked how long they had been struggling with the current mental health problem for which they were seeking treatment, responses ranged from "16 years" (Participant 4) to "the last three or four years" (Participant 8). Participants' mental health problems that were severe and chronic tended to span across many years. However, some participants with mental health problems that spanned across many years did not identify their problems as severe. Instead, they described their struggles as manageable, which was similar to participants with late onset mental health problems. In contrast, some participants with a late life onset (e.g., experiencing caregiver stress for the first time) described their problem as very severe and burdensome.

Theme 2: The illness career. The second theme centered on the factors that shaped participants' illness careers. Illness careers begin outside of a physician's office, when an individual first displays behaviour that is judged, by themselves or others, as being outside a range that is considered "normal" for that particular individual, in that social context (Perrucci & Targ, 1982; Twaddle & Hessler, 1987). It represents an individual's attempts to deal with their mental health problem(s), including what they do and when they do it. These factors fell into three categories: conceptualizing mental health problems, key entrances into patient role, and key timing and sequencing.

Conceptualizing the mental health problem(s). When participants first experienced their current mental health problem, they discussed how they made sense of the changes that were taking place and how they felt about what was happening to them. Based on these descriptions, three categories emerged under the conceptualization subtheme: problem identification, beliefs about causes, and outlook on mental health.

Problem Identification. During the interview participants discussed what brought them in

for treatment at St. Boniface hospital. The majority of participants described that they began to not feel like themselves. One man said,

I started getting disoriented and developed a fear of being unable to understand what people are telling me or what I'm reading. That doesn't happen to any significant degree but I'm so terrified of it that I'm very sensitive. So every time I misread a word, I go back and check and see. It's becoming more and more frequent that I do misread words or I hear things that people haven't said so it's almost like a hallucinatory sort of thing (Participant 15).

Another man said, "I was walking around and feeling a little weird, I don't know why, it was almost like something was brewing in the way of, maybe anxiety about mobility, I'm not sure. I remember feeling edgy a lot of the time" (Participant 11). In line with this, participants also described feeling overwhelmed, (e.g., "It was the outside stuff that caused the inside stuff, just being overwhelmed, it was really overwhelming for me" Participant 6). Moreover, many participants described that they began to experience somatic symptoms (e.g., "Every new pain or ache my mind just seems to have a mind of its own and it takes me places I don't wanna go" Participant 10), which they originally sought help for. It was not until medical professionals ruled out that there was not anything physically wrong with them that they began to realize that it was a problem with their mental health. One woman said,

I know that I've been checked, like I had my hearing checked and sometimes, when I'm feeling anxious, I feel like I get this banging in my head, it's almost like a ringing. I did the hearing test and had an MRI done. Nothing's wrong but there's still that feeling of what is wrong. Every time I get a test, nothing is wrong so it is up here [*points to head*] (Participant 12).

In contrast, another participant described being unsure that there was a problem and did not realize until she began to see a psychologist that there was something wrong with her mental health, (e.g., I didn't even notice before and it wasn't until I had those couple of years with Dr. X [psychologist] that I realized, oh wow I've been missing out on a lot," Participant 10.)

Beliefs about causes. Participants' explanations of what they think caused their mental health problem(s) varied among biological (e.g., brain-gut connection, genetic predispositions, etc.), psychological (e.g., "it's part of my personality"), and social (e.g., caregiving effects, dysfunctional relationships, etc.) causes and sometimes, a combination of the three. When asked what she thought caused her mental health problem, one woman described a biological explanation and said,

I do have the brain gut connection going on. If I have friends over [my stomach pain] would get so bad that I just couldn't wait for them to go. I would never say that but my gut was hurting me so much. And from the literature that I read about the brain gut connection I thought oh, I'm a primary example of that (Participant 2).

Similarly, another woman contemplated genetic predispositions as the cause of her anxiety and said,

I found out after [my dad] died and we got hold of his medical documents that he suffered from anxiety as well. So perhaps it's a bit familial. [My son], Dan, has had bouts of depression too, so we're a screwed up family (Participant 3).

Other participants talked about how their personality may make them more vulnerable to experience a mental health problem (e.g., "You know I was afraid to make a mistake, I always felt that I had to be perfect. Not anything that anybody ever laid on me, it just came from within" Participant 10). Similarly, one man said,

I think of myself as being kind of sentimental or nostalgic and I reckon this has always been a double-edged sword. You can feel great about things because you're more tuned into them but at the same time you're always aware of time passing and things going away so that can be a little sad, so it's probably as much my own make up as anything (Participant 11).

Some participants also described that their mental health declined because of social causes such as caring for a sick spouse or parent, dysfunctional family relationships, and bereavement (e.g., "I think the grief part was influencing me in lots of ways and it was making me anxious and fearful and lots of negative kinds of things" Participant 2).

Outlook on mental health. Nearly half of the participants described having a positive outlook on their mental health, which included stories of resiliency, optimism, and feeling grateful. One woman said, when describing how she felt after experiencing a traumatic life event, "I had to let it go because I had to survive. I have three children, three grandchildren, I have a wonderful husband. There was no way I was going to let that ruin my life at all" (Participant 3). Similarly another woman said,

That's why I've tried so hard not to become down and negative because once you start on that path you feel a little bit bad and then you feel a lot bad and then you feel very bad. If you fill your mind with anger and hurt feelings and disappointment, that's the direction you take yourself in (Participant 1).

Additionally, one man described feeling resilient, even during difficult times and said, "I think I'm lucky, I don't know why but I always bounce back quickly once I can get my ducks in a row, then I'm fine" (Participant 14). In contrast, some participants described having a pessimistic outlook on their mental health, and described being very critical of themselves, experiencing

hopelessness or thoughts of ending their life, embarrassment, and feeling that their mental health problem(s) prevented them from living a “normal life.” When one man believed he had dementia, he said, “Oh I’m a catastrophizer, I’m a huge pessimist so this is why I was contemplating stepping in front of a train” (Participant 15).

Key entrances into the patient role. Throughout the interview, participants described their experiences seeking psychological care and discussed key moments when they recognized and accepted themselves as the patient in need of care. Key entrances into the patient role were classified into three categories: a readiness for change, worsening of symptoms/sick role and bystander role/invisible patient. Some participants said that, although they were not experiencing a significant amount of distress, or a mental health problem, they were hoping for some sort of positive change in their lives. One woman said, “In the back of my mind I keep thinking am I crazy or what’s wrong, I don’t see myself as being entirely sick but I do have my problems and I wanna sort that out, I wanna be happy” (Participant 12). However, the majority of participants described experiencing a worsening of symptoms such that at some point they saw themselves as “sick” and in need of help (e.g., “I think it was only in the last number of years otherwise I wouldn’t dare go [see a psychologist] but then I got real desperate” Participant 8). In contrast, participants who were caregivers talked about how because their spouse or parent was always the patient, they were so consumed in their role as the caregiver that they did not identify themselves as in need of care. One caregiver described a conversation she had with her mother’s social worker and said,

Kim [*social worker*] said sit down and talk to me and one thing led to another and we were just talking and then she recognized that I needed some help and she said we need a

family meeting, something needs to be done, you need some help, but I didn't really recognize that I needed help (Participant 4).

Key timing and sequencing. Throughout the interview, each participant described how the timing and sequencing of contact with the treatment system influenced their entry into the patient role. From the key timing and sequencing subtheme, two factors emerged: ordering of consultations and accessibility of care.

Ordering of consultations. When asked about their path into the treatment system, the majority of participants described an indirect process, involving multiple steps and a variety of health practitioners. All but one of the participants first sought help from their primary care physician, who functioned as the gate-keeper to connect them to various other specialized services. Additionally, the majority of participants were experiencing somatic symptoms, which originally prompted them to talk to their primary care physician, who often referred them for neuroimaging and additional testing to rule out physical causes. One man, who was experiencing headaches and memory problems said,

I went to see my family doctor, he sent me to Dr. X [*neurologist*] who has a memory clinic. And his analysis was that my memory is better than average for someone my age and if I've got a problem, it's anxiety. So then he referred me to a psychiatrist and I met with him and brought my wife. But when I met with him he went off with my wife and I was left with a resident. She was a very junior resident, somebody who was doing a rotation through psychiatry and she didn't seem to know what she was doing. She asked me a lot of questions and didn't seem to respond appropriately to my answers and then he came back in and he is the most disengaged medical practitioner I've ever had. I mean he wasn't rude, like Dr. X [*neurologist*], but he was like, take it or leave it you know? And

he said, 'You know, there are ways you can improve your mental health but if you're depressed most people just take pills.' And I said well I don't want any antidepressants so Dr. X [*psychiatrist*] said, 'Okay, well then I'll refer you to somebody who doesn't have a prescription pad.' Then, the next thing I got was a notification I should go and see somebody named, Dr. X [*psychologist*]. So I did (Participant 15).

In situations where participants had identified themselves as experiencing a mental health problem, which prompted them to go to their primary care physician for help, most of the primary care physicians made a referral to psychiatry prior to making a referral to see a psychologist. One woman said,

My doctor referred me to the psychiatrist but then I went from the psychiatrist to a psychologist. I think because I was struggling a lot she thought seeing a psychiatrist would be good, but it really wasn't the right, it was the wrong referral (Participant 2).

Accessibility of care. In line with the ordering of consultations participants experienced, they described how accessible they perceived treatment to be. Some participants described this process as slow, time-consuming, and frustrating. Even though primary care physicians were accessible to all participants, some participants described their primary care physicians as being unhelpful because they prevented them from getting the treatment they wanted. One man who was struggling with depression said,

I went to Dr. X [*primary care physician*] and I asked him for an increase in my [antidepressant] pills. He said, 'Well, I can't. You're taking the maximum now, you can't take anymore.' He said, 'You know, try and take it easy,' and uh no matter what I said he wouldn't refer me. I said, 'Well, I need help,' and he says, 'I'm reluctant to have you go to a psychiatrist because I don't want you take that strong medicine.' And so he

says, 'Try taking the citalopram half in the morning, half at night to even it out,' but that didn't work very well. There were a couple of times I walked out in the kitchen here at night, I was thinking of taking all my pills but I wouldn't have done it. But the thought was there and that's what scared me. And the only thing that got me to the psychologist was when I went to a thing for my pacemaker, the doctor there looked at my prescription says, 'Oh, citalopram, so you have some depression?' I said, 'I have a terrible time with depression,' and she says, 'I'll look after this.' Within a week or so I had my appointment but it was really a struggle to try and get help. It was really a tough, tough time to get help (Participant 8).

Despite the difficulty participants had before receiving what was described as the "right referral" to a psychologist, most participants were satisfied with the outcome. One man said,

It's quite a lot of small, it wasn't one major incident that happened and that was the starting point, it was several steps to get there. In fact four steps for me to get there [to a psychologist]. It was time consuming as anything to do with health issues in Canada, but when it [seeing a psychologist] happens, it's brilliant. It's absolutely marvellous (Participant 14).

Theme 3: Social support system. The third theme emerging from the interviews centered on participants' social support systems and the interactions that took place within their social network regarding their current mental health problem(s). The content of this theme subdivided into four subthemes: network structure, attitudes toward disclosing, experience of disclosing, and community network functions.

Social network structure. The network structure of participants' current social support system consisted of three factors: network members, the frequency of contact participants had

with their social network, and the quality of these relationships. Network members consisted of family, friends, and neighbours. Some participants described having a large social network with many members that they could count on for support. In contrast, other participants described only having one or two people in their life that made up their social network, which consisted of a spouse or a few close friends.

The frequency of contact participants had with the members in their support system also affected the social support network structure. Despite the size of the network structure, the majority of participants described that they were in contact with friends and family on a regular basis, either in person or on the phone. One man, who came from a large family, said, "I had my whole family for help, I was never alone" (Participant 13). Another participant, who did not have as many members in his social network said, "I get out with Doug once in a while for coffee, about once a week, so that's kind of nice" (Participant 8). Even when the size of some participants' social network was small, the frequency of contact they had with these members had a larger impact on them than the actual number of members in their social network. In contrast, a few participants who also had small social networks reported that they did not see or hear from people very often, and they described feeling isolated and alone. One woman, whose family lived in a different city, said "My son can't have us down there because they're working, it's hard" (Participant 5).

Lastly, the quality of relationships participants had with their social network members contributed greatly to the overall network structure. Most participants described having strong bonds with certain friends and family in their social network. When asked how supportive his sister was during times he was struggling, one man said, "Absolutely she's been a consistent support for me. She worships me, I don't know why" (Participant 15). Similarly, another man

said, of his relationship with his son, "It's a good relationship, it's a warm relationship, it's an open relationship" (Participant 14). In contrast, other participants described having a strained and distant relationship with some family and friends in their social network. When asked if there was anyone who was unhelpful to him as he sought help for anxiety, one man said,

My wife ironically is a problem, she's more reactive than proactive and I think by nature she's a bit negative. She's not the easiest person to talk to; it's sort of that way with her whole family. So communication isn't a big thing in her family...it kind of spills over here as well (Participant 11).

Attitudes toward disclosing mental health problem(s). Participants described having a variety of positive and negative attitudes about disclosing their mental health problem to their social support network. The majority of participants had negative attitudes toward disclosing including concerns about being perceived differently, not wanting to burden others, not trusting that others will keep the information private, and a belief that others will not understand what they are going through. One woman said,

I think that people who have not gone through this, and most of my friends fortunately haven't had to, don't quite understand. So I'm not going to, I don't like to say, 'Well, I'm really having a bad day today.' You know, everybody's got their own problems and they've got their own lives and they're not gonna worry a whole bunch about what's happening with me, even though they are friends. Not everybody knows what I go through, not everybody knows, even friends don't know that I maybe saw a psychiatrist or that I am seeing a psychologist. I haven't really made that public. I think what happens is that other people really don't wanna know that about you. Like you're not

gonna burden your friends and your family, you don't want them to think that you're needing help and they don't know what to do about it (Participant 2).

In contrast, a few participants described feeling very comfortable with disclosing their struggles and mental health problem(s) to their social network, although that comfort depended on to whom they intended to disclose their problems. Some participants felt more positive about disclosing if they perceived their social network members as understanding, open, or having shared a similar experience. When asked if there was anyone in his life he could talk to about personal matters, one man said, "Certainly my son, we can talk openly with both sons in fact" (Participant 14). Similarly, one man said, "I would say that I identified myself as needing assistance. I recognized it very quickly and as a result I shared this with my wife and my kids because [I knew] they cared" (Participant 13).

Experience of disclosing mental health problem(s). During the interview, participants also discussed their positive and negative experiences disclosing their mental health problem(s) to their social network. After disclosing to members in their social network, some participants felt understood, less alone, and more supported. One woman said, of a friend she had disclosed to, "Well she knew exactly how I felt, I mean, I didn't wanna be alone" (Participant 9).

Similarly, one man described feeling supported and understood by his family when he disclosed he was struggling with depression. He said,

I shared it with my family who was intimate with me and with my wife, so she knew everything was going on. I didn't hold anything back so thank goodness I was able to do that and she was there to listen. So I was lucky, very lucky (Participant 13).

In contrast, many participants described having a negative experience after disclosing to friends or family about their mental health problem(s). A few participants discussed losing family and

friends who were tired of listening to them talk about their struggles with mental health problems. One woman said, "I lost a couple friends over this cause they got tired of listening to me talking about it all time, but I have nothing else to talk about. They just got tired of listening, which is kind of sad" (Participant 4). Other participants described feeling overwhelmed by people trying to be too helpful after they disclosed to friends or family about their mental health problem(s). One woman said,

I get angry at my sister and one of my friends, Barb, because they're trying to be too helpful and too directive. If anybody was too helpful and too directive it was me, you know? I was the go-to person and with my sister and brother, I'm the eldest, and so I resent some of what my sister's telling me to do. Although I've accepted that she does all this to try to help me...I think we have the kind of relationship where we might resent each other at times (Participant 7).

Some participants also discussed experiencing stigma and not feeling understood by the family and friends they confided in. One woman said, "To be constantly told, like Jeff [*husband*] says to me, 'oh, go take your crazy pills'. I don't need to hear that" (Participant 12). Similarly, one man discussed the stigma he felt from his wife and her beliefs that he would never get better and said,

So with this problem she's not helpful in her attitude toward [me] because she thinks that I can't do anything and she's always reminding me of that. If it were just a friend you saw every two months who would say, 'Oh, you're not getting any better well you never will, you know.' Well you don't, maybe you don't take that seriously but if it's somebody who's around all the time, that's different. So it's a curious mix of [her] being very helpful but very negative. You know, it almost feels like you're in a nursing home

and you know the attendant is helpful but they don't think you're ever gonna leave
(Participant 11).

Similarly, one man described not feeling understood by his wife and said,

Sue tried cheering me up, she says, 'Look at you, you got so much to look forward to,' and all this kind of stuff. I was crying all day and one day she said, 'Get a grip, life is good.' And so you know what? I don't blame her cause she doesn't understand what a person goes through (Participant 8).

Community network functions. In discussing the main functions of their social network, participants described that their network provided them with information, advice, emotional support, and practical support. Participants viewed the majority of their community network functions as helpful, but some functions were not (e.g., unsolicited information or advice). In terms of information received, one man who was struggling to cope with his wife's Alzheimer's disease diagnosis said, "I was chatting to my son in a general sense, not specifically saying now what about Pam (*wife*) or what about me, but in a broader sense. Well, he certainly gave me insight into the facilities offered by Manitoba Health" (Participant 14). Additionally, participants' social network also provided them with advice, which consisted of advising them to take better care of themselves and encouragement to seek help. One woman said, "My cousin, used to say to me all the time, 'you've gotta stop doing this and doing that, you're gonna make yourself sick,' and she was right" (Participant 4). Similarly, one woman was encouraged by her friend to seek help for her depression. She said, "My friend knows that I was seeing somebody, I think what happened was I was telling her I was having some difficulties and she said, 'Well really, just seek out whatever help you can get, don't hold back'" (Participant 2). Participants also received emotional support, which consisted of members in their support network showing

them empathy, compassion, and genuine concern for how they are doing. One woman said, “I couldn’t ask for a better support network...they were there for me with my first husband [dying] and now they’re here for me with this. And any of them, I would do anything for them” (Participant 7). Lastly, participants also received practical support from their social network, which consisted of household chores, getting them out of the house for a walk, and transporting participants to and from their appointments. One woman, whose husband needed to be moved into a personal care home, spoke of the help she received from a friend during that time and said, “I had a friend staying with me for eight days. He helped out with everything. I also had some friends from Regina that stayed here” (Participant 1).

Theme 4: The treatment system. The fourth theme centered on the factors that make up participants’ treatment system. In line with the NEM-II, the treatment system includes a changing set of providers and organizations with which participants may have contact (Pescosolido & Boyer, 1999). Similar to the social content, illness career, and social support system, the components of the treatment system change over time due to the various physical and mental health problems people have, health care advances, societal resources, and because of community demands and preferences. These factors subdivided into four categories: treatment network structure, attitudes towards treatment, experience of treatment, and treatment network functions.

Treatment network structure. Similar to the social network structure, the network structure of participants’ treatment system consisted of three factors: network members, the frequency of contact participants had with the treatment system, and the quality of these relationships. Network members included primary care physicians, mental health professionals (e.g., psychiatrists, psychologists, social workers), and health professionals (e.g., neurologists,

cardiologists, nurses). As previously mentioned, all but one participant first sought help from their primary care physician who functioned as the gate-keeper who was able to refer them to specialty providers (e.g., psychologists) and additional resources. The frequency of contact participants had with treatment members also influenced the overall treatment network structure, which ranged from one short visit to over 23 years spent with the same physician. One woman said, "We've been going to the same family doctor for many, many years. He certainly knows what's happening and he is good to talk to but he isn't around all the time, he travels" (Participant 5). In terms of participants' frequency of contact with psychologists specifically, sessions usually occurred once a week for approximately an hour. However, some participants described not seeing their psychologist as often due to conflicting life circumstances (e.g., busy taking care of a sick spouse, travel obligations, moving, etc.). One woman said,

I haven't seen Dr. X [*psychologist*] for the past month, things started to get goofy, like we had to close the cottage, my husband was away and then I know Dr. X was away for quite a bit. We got off the track, so this was the week that I was to phone everybody and say okay, let's get going on this (Participant 7).

Additionally, the majority of participants were in contact with their primary care physicians more frequently than any other medical professional, because they described always needing to go through their primary care physician first in order to connect with additional resources in the community (e.g., referral to psychiatrist, psychologist, neurologist, etc.). Lastly, participants' relationship quality with treatment network members contributed momentously to the overall network structure. Participants described that the quality of these relationships was determined by how helpful they viewed treatment network members, their bedside manner, and the amount of experience professionals had in their specialized field. Additionally, the quality of these

relationships influenced whether participants continued seeing a medical professional or not and how committed they were to their treatment plan. Some participants who had a negative experience with a medical professional eventually had a positive outcome due to a change in physician and treatment options. One man said, of his first experience with a psychiatrist, who ultimately referred him to a psychologist:

It was almost an insulting interview, you know when I left I was angry at him because of his disengagement, his lack of concern, his trivialization of people's pain. Here's a psychiatrist who acts like he's dealing with a sore back or something. And you know, he's not a back specialist and I don't wanna take the pill he wants to give me for my back so I'll go and see somebody else. And that's really all, he just wanted to get me out of his office so that was an unpleasant [appointment] but it actually was incredibly helpful [because he gave me the referral to my psychologist] (Participant 15).

Additionally, one woman who was reluctant to begin seeing a new psychologist, after she had formed a good relationship with her previous psychologist said,

It was kind of funny cause I didn't wanna change cause I liked Dr. X [*previous psychologist*]. I thought well you gotta get to know somebody all over again and I first said I didn't really wanna go, and then I said, well I will. I'm so glad that I did cause Dr. X [*psychologist*] is awesome (Participant 4).

Despite participants' describing the importance of their relationship with their primary care physicians, some felt that once their primary care physician made a referral on their behalf, they were not longer as invested or concerned about their mental health. One man said,

I never had any issues with bringing it [anxiety] up with him or talking to him about it. I may be a little bit surprised that he hasn't, now that he's referred me to Dr. X

[*psychologist*], it's almost like he feels he's offloaded the issue. So when I do go see him for an annual or whatever, he doesn't really ask about it or anything, doesn't seem interested in it. And I think if I were somebody's doctor I would stay at it. So I mean I had no problem bringing it up with him and a few times, I'd even asked him questions about it but he doesn't really have too much to say. I mean maybe he doesn't really know what it's all about and he's just kind of relying on [my psychologist] or whoever to deal with it, I don't know (Participant 11).

Attitudes toward treatment. The majority of participants discussed having a treatment preference for their mental health problem(s), in comparison to a few participants who described having no preference at all. Their preferences were influenced by past experiences, including what treatment options had previously worked for them and what kind of medical professionals they had contact with. Participants' treatment preferences, in order from least commonly preferred to most, consisted of pharmacological treatment (6.7%), a combination of the pharmacological and psychological treatment (13.3%), no preference at all (26.7%), and psychological treatment (53.3%). Some participants described that getting a prescription from their primary care physician was usually their first course of action and that they thought medication would "fix them," or at the very least, provide some relief. One woman said, "I'm looking at my little box of bottles here and these are sleeping and those are blood pressure and cholesterol, but this one here, clonazepam. If I'm feeling stressed, it's amazing what one of these will do" (Participant 2). This participant also discussed how having therapy in addition to her medication was her ideal preference and what worked best for her. In contrast, another man who was asked if he had a treatment preference for his depression said, "Medication, I thought that would do the trick but that didn't work" (Participant 8). Other participants, who described

not wanting medication, also discussed not having a preference for psychological treatment either. Participants described having no preference due to a lack of information about the treatment options available and how effective they were. One man said,

I would never have gone to a psychologist if they hadn't referred me. Why the hell am I going to see a psychologist? They don't deal with people, they're scientists. They collect data about huge studies and they make small statements that are very true. But they don't deal with individuals, right? But that's not true (Participant 15)!

Lastly, the majority of participants described having a preference for psychological treatment. Some participants discussed that psychological treatment was their preferred choice simply because they did not want to take (another) medication, which some viewed as masking the real problem that was affecting their mental health. One woman said, "I wanted therapy...I don't wanna take medication because the medication is only gonna do something to my brain to make me feel better but it's not really getting rid of the problem, you know" (Participant 6). Similarly, one man said,

I don't take pills; I don't take mood-affecting pills. I've never. I take lots of medicine but that whole thing about changing your brain; I just don't wanna do that. It just feels like, you know, turn around and face it, [I] should be facing things that are bothering me not masking them with chemicals (Participant 15).

Other participants who described having a preference for psychological treatment explained that they wanted therapy to help get better control over their lives, for information or advice, and to have someone they could talk to confidentially, who would help them address the problem head on. One man said,

That's what I'd like from [my psychologist] is a kind of sense that I have some control over this and over my future, you know? I'm hoping to get good advice. I asked if I could speak to psychologist to pick his brain, her brain, find out what the future holds, how I must handle it (Participant 14).

Additionally, some participants described that their current experience with a psychologist made them wish they sought help during earlier times in their life when they were struggling with their mental health. One woman said, "I probably should have done that long ago, just to have someone to talk to and who understands" (Participant 5).

Experience of treatment. Throughout the interview, participants discussed the type of treatment they received for their mental health problems, in addition to the benefits and drawbacks of treatment. As previously mentioned, all of the participants received therapy from geropsychologists at St. Boniface hospital and only one participant had completed this treatment at the time of our interview. Additionally, seven participants were taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and benzodiazepines, in combination with therapy. Both benefits and drawbacks to psychological and pharmacological treatment for their mental health problem(s) were discussed.

Psychotherapy. Although participants described benefits from both psychological and pharmacological treatment, substantially more benefits were noted from the psychotherapy participants had received and they did not report any drawbacks from this treatment. All of the participants described a number of benefits from receiving psychological care including that it was a supportive environment that was confidential (e.g., "So that was one of the good things [about therapy], that I could talk about things but nobody's gonna know about it" Participant 6). Additionally, participants described benefitting from psychologists who normalized and

validated their feelings. When asked what he found beneficial from therapy, one man said, "Recognition of my humanity and that lots of people have the kind of pain I do helps (Participant 15). Similarly, one woman said, "It's been nice having somebody to talk to that can give me some feedback cause I mean, I can talk to my husband, I can talk to my kids but it's usually, try not to take it personal mom" (Participant 4). Participants also described benefiting from information or advice they received in therapy. One woman, who was receiving therapy for caregiver stress said, "I'd like to keep going [to therapy] as long as I can cause it's a great outlet for me and it really helps because Dr. X [*psychologist*] knows all the stages of dementia and so that's been a big help" (Participant 5). Lastly, participants said that therapy helped give them hope for the future, which allowed them to enjoy life again. One man said, after he received therapy for depression:

What was left there was a little bit of hope and just the fact of even being able to talk to Dr. X [*psychologist*]. I could talk to him about things that the rest of them would think that I was, you know, out in left field or something. Nobody wants to hear about my problems. Pam [wife] doesn't wanna hear it; Cliff [friend] doesn't wanna hear it. Maybe in a way that's good, that's okay cause you don't wanna depress anybody. And finally when I got to see Dr. X [*psychologist*], I started enjoying life again (Participant 8).

Pharmacotherapy. Participants discussed fewer benefits of pharmacotherapy in comparison to psychotherapy. Benefits of receiving medication for their mental health problem(s) included, that it was a quick fix, helped manage their symptoms, and made them feel better knowing there is something they can depend on. However, participants reluctantly described these benefits with provisos regarding concerns they had about them. One man, who takes anti-anxiety medication, said,

It was helpful, quite helpful. If I have to do something really stressful, like make a speech at a wedding or something, then you know I might take more of the clonazepam and it does have a huge effect. But you gotta watch it because it makes things too easy, almost like there's nothing wrong with you and you can forget that you need to find other ways, you know, other solutions (Participant 11).

Similarly, one woman, who was also taking anti-anxiety medication, said:

It seems to just bring my stress level down. It seems to work for me and, you know, it's about time for a refill. I know that psychologists aren't keen on taking medication, I know that, but for me I probably want to have it, just as a crutch (Participant 2).

Despite the benefits that were discussed from pharmacotherapy treatment, a few drawbacks were noted. Two drawbacks of pharmacotherapy included mental health symptoms worsening and concerns about depending on medication. One woman who tried antidepressants to help manage her symptoms said, "They had given me medication and it made me feel even worse, I felt suicidal" (Participant 6). Additionally, one man said, "I don't want to depend on anything, which bothers me with the clonazepam. It's a crutch, you know, which I don't like to rely on" (Participant 11).

Treatment network functions. Similar to the social support network, participants described that their treatment network provided a number of functions. Similar to the functions provided by participants' social network members, treatment network members also provided information, advice, emotional support, and practical support. Some participants viewed their health practitioners, including generalized and specialized health professionals, as a great source of information regarding treatment options available to them, who they should go to for additional help (e.g., referral to psychiatry), and for feedback regarding their mental health. One

woman, who was experiencing somatic symptoms, in addition to anxiety, said that her psychologist gave her information that helped her understand what was going on with her (e.g., “Last summer Dr. X [*psychologist*] gave me literature on it, and this is something that we were kind of working on a bit was understanding the brain gut connection” Participant 2). Some participants, who identified as caregivers for family members with dementia, described getting psychoeducation from their psychologists about dementia and what to expect (e.g., “Dr. X [*psychologist*] really helps me cause she knows all the stages of dementia and, you know, what to do and that’s been a big help” Participant 5). Additionally, participants described how members in the treatment system provided them with advice, which consisted of advising them to take medication, attend therapy, or make positive changes (e.g., socialize more) to improve their mental health. One man said,

It’s funny I wasn’t thinking about medication but I was talking to the social worker who is attached to the clinic where my general physician is and she had suggested clonazepam. She thought that I was at that point, you know, I was a little unstable and I guess she thought it would be helpful (Participant 11).

Additionally, one woman, who was seeing a psychologist for caregiver stress, described the advice she received, which she found helpful:

Dr. X [*psychologist*] makes suggestions sometimes, which I found really helpful, and Dr. X [*psychologist*] supports me in things, like that it’s not necessary to go [visit my mom] every day. People are always asking me, ‘Do you go every day?’ What’s with that? I said, ‘I know people who do that,’ and Dr. X [*psychologist*] said, ‘It isn’t always the healthiest plan.’ She said, ‘People who go every day and stay for hours, that isn’t necessarily a sign of health’ (Participant 1).

Lastly, participants described being encouraged and advised by practitioners to socialize to help improve their mental health. One man said, “Dr. X [*psychologist*] said that I should get out and see people and so that’s why I joined that seniors group, so I do that” (Participant 8).

Participants also received emotional support, which consisted of empathy, compassion, and a genuine concern for how they are doing from members in the treatment system. One dementia caregiver described the emotional support she received from a psychologist and said, “I really, really feel that I can go in and be upfront, I deal with it right then and it’s acknowledged. And that is the biggest thing that I need, the acknowledgement that I have the right to exist” (Participant 3). Additionally, some participants described that their psychologists and primary care physicians accepted and understood them, which is something they did not feel from their social network (e.g., “My psychologist listens and understands what I’m saying and understands what I’m going through” Participant 10). Similarly, one man said, of the support he receives from his psychologist, “I think Dr. X [*psychologist*] holds my hand figuratively speaking, you know, when I have my appointment I always feel better when I leave because Dr. X [*psychologist*] normalizes things” (Participant 15). In addition, one woman who felt anxious and depressed, described feeling understood by her psychologist and said, “I think Dr. X [*psychologist*] helped me, Dr. X [*psychologist*] said, you have a social face and you have a private face and you can put on a social face but your private face is something totally different” (Participant 2). Overall, although participants described receiving emotional support from both their primary care physicians and psychologists, they were especially likely to report receiving this type of support from psychologists.

Lastly, several participants described receiving practical support from their primary care physicians when they requested a specific referral and their doctor agreed to provide it. This was

considered to be practical support because they described that they would not otherwise be able to see certain specialized health professionals without this referral. This was the only form of practical support described by participants. One man said,

I was the one that found an article about [my psychologist's] program in the Free Press [newspaper] and then I had to mention it to him [*primary care physician*]. And like a lot of doctors, you gotta punch them between the eyes before they do anything and I told him about this program...he said oh sounds good to me so he gave me the referral but everything was my doing (Participant 11).

In contrast, a few participants discussed experiences they had when their treatment network was not functioning well. For example, participants were given misinformation, did not feel respected or supported by medical professionals, and felt as though they were not important enough to the physician treating them. One man who was trying to get help for his depression said,

I phoned health links and they said, oh don't bother because we can't really help you too much, you have to go one of these places in the newspaper because it'll be seven or eight months before you can go see a psychiatrist so, that's your best option (Participant 8).

Pathways to Care

After documenting participants' experiences with the social support network, the treatment system, and their past and present experiences with mental health problems in the thematic framework (Figure 2), my research team and I identified their overall pathways to care. In exploring how older adults access treatment, we remained mindful of the diverse ways they obtained care, including the influence of their social contents, illness careers, social support networks and treatment systems (Pescosolido, Gardner, & Lubell, 1998). We first identified

pathways to care based on Pescosolido and colleagues (1998) theoretical definitions of choice, coercion, and muddling through. Accounts of “choice” were defined as individuals who indicated, *at any point* during the interview, they made a decision that they wanted help, or at least clearly agreed to seek care for their mental health problem(s). In contrast, Pescosolido and colleagues (1998) defined accounts of “coercion” as an active resistance to treatment, including a lack of agency and control in making treatment decisions for their mental health problem(s). Lastly, accounts of “muddling through” were defined by pathway accounts that lacked agency, choice, or resistance (these individuals may be unclear or confused as to how they entered the mental health system). Based on these definitions and the themes and subthemes that emerged from the interviews, we categorized participants’ experiences of seeking help for their mental health problems into stories of choice ($n=11$), coercion ($n=1$), and muddling through ($n=3$).

Accounts of choice. Eleven of the fifteen participants’ pathways into the formal treatment system reflected an active choice to seek help for their mental health problems, which were further conceptualized into an *individual choice* ($n=4$) or *supported choice* ($n=7$). Participants who made an individual choice were those that described making a decision on their own to seek help, without the influence or input from the social support network or treatment system (e.g., “I would say it [getting help] was primarily self-driven” Participant 11; “It was all me, getting help for it [anxiety] was driven by me” Participant 15; “I helped out a lot of people and it’s my turn to get the help” Participant 12). Participants who made a supported choice were those that described their choice to seek help was embedded within their social network and discussed how members in their social network suggested, supported, and influenced their pathway to care. One man, who was struggling with depression, said:

I don’t think I was forced into it [psychological treatment], I certainly accepted the idea

and when it really happened, I found it quite acceptable. My wife was the biggest guideline to me. Certainly my son, the doctor, supported that decision [to seek help]. And so did I (Participant 13).

Accounts of coercion. One participant described a coercive pathway into the formal treatment system. Accounts of coercion can be categorized into 'hard' (i.e., formal measures such as involuntary hospitalization) and 'soft' (i.e., pressure from family, friends, and health professionals to get and stay in treatment) coercion. One woman, who ended up in the hospital, because of signs of a possible heart attack, described a pathway of soft coercion and said,

They [*hospital staff*] made the assumption there's a possible heart attack but there wasn't. And so it was decided that it was my sugars that were out of whack...so I was in the hospital for about three days while they worked their magic and tests and stuff to see what it was and what it wasn't and then they decided it...I went to the geriatric day hospital for a couple of sessions and it was decided that I would see Dr. X [*psychologist*]...She [*sister*] said, 'How come you still have to go to see a psychologist, like what is Dr. X [*psychologist*] supposed to be fixing?' And you know, after awhile you sort of lose track and so I asked Dr. X [*psychologist*], 'What are we doing here?' Dr. X [*psychologist*] said, 'They had'...I don't know who they is but, I guess the team, one of the things that had been discussed was that I was having a hard time adjusting to retirement (Participant 7).

Accounts of muddling through. Lastly, we categorized accounts of muddling through into two forms of muddling: (a) someone else took over the decision making process, or (b) there was no clear agent or decision maker. Three participants did not describe an active choice or a resistance in their pathways to care. Rather, their description of their path into psychological

care was unclear and they described being slightly confused as to how they came to receive help for their mental health problem(s). When one woman was asked to describe her experience into the treatment system, she said, "I don't know how I got in [to treatment]. It was suggested that I go and talk to a psychologist and that they would help me. I don't know how- I didn't seek out Dr. X [*psychologist*]...for some reason we were just connected" (Participant 5). Although only three participants met the full definition of muddling through, in the end, the majority of participants' interviews had some component of muddling. Despite that the majority of participants' interviews were accounts of choice based on the definition above, their experiences were also filled with many challenges and drawbacks. More specifically, thirteen of the fifteen participants' interviews were filled with accounts of muddling through at some point during the interview. Therefore, a quick, direct, and efficient entry into the formal treatment system did not characterize how older adults ended up entering treatment for mental health problems, and further conceptualization regarding pathways into care is warranted.

Discussion

This study is the first to use the NEM-II as the theoretical foundation to qualitatively examine older adults' experiences seeking psychological care for their mental health problems. The objective of this study was to gain an in-depth understanding of how older adults with mental health problems come into the formal treatment system and to explore the dynamic and changing interactions between those suffering from mental health problems, their contexts, and their interactions with their social and treatment networks, using the NEM-II. Overall, data from this study suggests that the NEM-II is an appropriate service use model to explore older adults' experiences with mental health problems and aligns with their experiences seeking psychological care. In line with the NEM-II, the findings from this study indicate that participants' background

(social content), social support network, and the treatment system influence and are influenced by participants' illness careers. The majority of participants' interviews highlighted a meandering route and challenges on their pathway to care, however, it is still unclear how best to describe individuals' overarching pathway to care (e.g., choice vs. coercion vs. muddling through), which requires additional research. Overall, a number of factors from participants' social content, social support system, and treatment system advanced and delayed help-seeking among older adults. These factors should be taken into consideration in future studies aimed at improving and increasing help-seeking among this population.

Pathways of Choice, Coercion, and Muddling Through

The NEM-II is an advantageous service utilization model to use with an older adult sample because it challenges both the rational choice logic and voluntary tone of dominant help-seeking and service utilization models, thereby making room for other possible pathways to care. However, the pathway definitions of choice, coercion, and muddling through by Pescosolido and colleagues (1998) were challenging to classify in this study. For example, we chose accounts of choice to represent pathways by individuals who indicated, *at any point* during the interview, that they made a decision that they wanted help, or at least clearly agreed to seek care for their mental health problem(s). Therefore, despite participants who had accounts of clear and sometimes lengthy periods of muddling through in their interviews, if they stated at any point during the interview they made a decision to get help, or explicitly agreed to seek help, we classified them as having travelled a pathway of choice. Yet, given that most of the story had accounts of muddling through, categorizing this path as choice did not seem to be the most accurate representation of an individual's story. Similar confusion existed in differentiating muddling (i.e., including accounts when a network member took over the decision making

process), from soft coercion, (i.e., including a lack of control in making treatment decisions and pressure from network members to get and stay in treatment).

One challenge in classifying participants' pathways into treatment was our perception of the need to make a decision about whether choice, coercion, *or* muddling through was most appropriate. Instead, another possible way of conceptualizing pathways into care might allow for participants' stories to contain accounts of choice, coercion, *and* muddling through. Therefore, instead of having to decide between these three overarching categories, perhaps it is more accurate and representative of individuals' experiences if their stories can be categorized according to the degree to which each of these processes (i.e., choice, coercion, muddling) were present. For example, someone might have a pathway in which they were initially mildly pressured to speak to their primary care physician, and then experience a period of muddling through the system following a referral, before eventually making a choice to pay for private counselling. In this example the individual could have moderate levels of coercion, high levels of muddling, and moderate levels of choice at different points in their pathway to care. This type of conceptualization would allow for a more expansive definition that may more accurately capture individuals' dynamic pathways to care. Given the complexity and dynamics involved in help-seeking and service use, additional conceptualization regarding pathways into care requires further investigation, about which I will speak to Dr. Pescosolido (B. Pescosolido, personal communication, July 7, 2016). Despite the fact that ongoing research is needed to clarify how best to describe the overarching pathways to care, a number of factors that delayed and advanced help-seeking were clearly identified in this study.

Factors that Delay Help-seeking

There were a number of factors that delayed participants on their pathway to seek help

for their mental health problems. First, a lack of support among some participants' social network members had a negative influence on those participants' ability to be open and identify that they have a problem, which sometimes resulted in a delay in seeking help. For example, when a few participants disclosed that they were struggling to manage their mental health, certain members in their social support system made stigmatizing comments or displayed a lack of compassion and understanding, resulting in participants feeling embarrassed, alone, and questioning whether they could actually get better. Participants described this lack of support and understanding as very unhelpful on their pathway to care because they wasted time trying to "live with it," taking the advice from certain members of their social networks to simply "smile and be happy." These findings were in line with a previous qualitative study that found older adults with depression endorsed a high level of public stigma, which negatively influenced their attitudes and intentions toward seeking mental health services (Conner et al., 2010).

A second factor that delayed help-seeking was "inappropriate" referrals from participants' primary care physicians, which caused a delay in what they described as receiving "appropriate" treatment from a psychologist. Given that older adults have more frequent contact with their primary care physicians regarding their mental health than any other medical professional (Klap et al., 2003), it is extremely important that primary care physicians are well informed about older adults' mental health and treatment options. Unfortunately, based on the experiences of older adults in this study who first sought professional help from their primary care physician, the majority of participants were first prescribed medication or referred to a psychiatrist, which involved a lengthy wait time prior to their first appointment. Their experiences were in line with previous studies that suggest primary care physicians are less inclined to refer older adults to psychologists (Alvidrez & Areán, 2002). Additionally,

participants' experiences were reflective of previous studies that found that older adults are at an increased risk of being prescribed psychiatric medications and are less likely to be treated with psychotherapy in comparison to young adult patients with mental health treatment needs (Bartels & Drake, 2005; Bartels et al., 1997). Moreover, some participants were taking medication for their mental health problems, prescribed by their primary care physicians, that have been associated with specific risks for older adults including drug interactions and an increase in falls (Hines & Murphy, 2011; Schellander & Donnerer, 2009; Vieweg et al., 2009; Woolcott et al., 2009). Participants who were initially referred to a psychiatrist were delayed in seeing a psychologist, even though some of these experiences were perceived as helpful because the psychiatrist ultimately referred them to a psychologist. Once participants finally came in contact with the treatment offered by a psychologist, all of them described that this was the "right treatment" for them and that the initial referral to a psychiatrist was inappropriate. It is possible that participants felt a referral to psychiatry was "inappropriate" because they were not properly informed regarding what an appointment with a psychiatrist would entail. Nevertheless, this clear delay in psychological treatment speaks to the importance of informing not only primary care physicians, but also older adults about treatment options available for mental health problems. In line with increasing knowledge translation among primary care physicians regarding treatment options for mental health, a third factor that delayed help-seeking was a lack of knowledge among participants regarding mental health and the resources that are available to them, which is referred to as mental health literacy (Jorm, 2012). Prior to their referrals to psychologists, two participants did not know about psychologists' roles or the nature of psychological treatment. Additionally, other participants believed the first line of treatment was medication, even though many participants described a reluctance to take medication for their

mental health problems. This lack of information regarding treatment options available to older adults resulted in a delay in participants seeking psychological treatment, which is what many of them perceived to be the most appropriate form of treatment. Similarly, a dearth of knowledge regarding mental health and service utilization was a commonly cited problem reported in a qualitative study by Ghesquiere (2013), exploring support seeking among older adults with complicated grief. Additionally, findings from a number of quantitative studies show that older adults experience difficulty when defining and recognizing mental health problems, in addition to their tendency to describe mental health problems as somatic symptoms (Farrer et al., 2008; Gum et al., 2010; Lee et al., 2010; Tieu, et al., 2010; Wetherell et al., 2009). When participants were asked if there were other times in their life that they would have liked to talk to someone like a psychologist, all but one said yes, and that they wished they had received help sooner. Therefore, had participants been better informed about older adult mental health and the resources available, it is likely this would have shortened the time it took them to access psychological services.

Factors that Advance Help-seeking

Despite the factors that delayed help-seeking and the time it took for participants to receive psychological treatment, there were a number of factors that advanced and facilitated mental health help-seeking. First, support from certain members in participants' social networks had a positive influence on their ability to accept that they were struggling and in need of help. Essentially, within each social network, there were network members who were helpful and others who were not, yet how helpful participants' social network was depended on whom my participants spoke to about their problems and the quality of these relationships. For example, if participants were frequently in contact with certain members in their social network and had

strong relationships with them, it was more likely that these social network members would identify changes in behaviour or functioning and help participants identify that they needed help, in comparison to participants who had a small social network with relationships that were distant or strained. Additionally, participants felt more comfortable to disclose their mental health problems to specific members in their social network who were perceived as understanding, open, or having shared a similar experience. When participants felt more comfortable to disclose and when members in their social network provided them with support, this positive interaction helped facilitate help-seeking among participants because they were encouraged, offered guidance, and did not feel alone in their struggle. This finding is in line with previous research, suggesting that older adults do not experience mental health problems in isolation. Rather, they face their mental health problem(s) throughout the course of their lives by interacting with others, including members in their social network, who may recognize a problem, send them to treatment, and support them regarding appointments, medications, lifestyle changes, etc. (Freidson, 1970a; Freidson, 1970b; Pescosolido & Boyer, 2010; Pescosolido et al., 2013).

Moreover, research suggests that members in an individual's social support network have been shown to reinforce the individual's worldview and self-concept, including the perception of need (Auslander & Litwin, 1990). Therefore, members in the social network can affirm the necessity for an individual to seek help, which was observed in this study. In contrast, some research suggests that individuals with strong connections in their social support network are less likely to seek formal psychological services and those who lack sources of support will more likely turn to professional care providers regarding their mental health concerns (Birkel & Reppucci, 1983; Bosmajian & Mattson, 1980; Linn & McGranahan, 1980; Sherbourne, 1988; Woodward et al., 2015). Given the conflicting information in the literature, further research is required to explore

the complex role of social networks in an individual's help-seeking process.

A second factor that advanced help-seeking was reflected in participants' descriptions of primary care physicians who identified that they had a mental health problem and made an "appropriate referral" to a psychologist. Given that primary care physicians are usually the first point of contact for any health ailment (Klap et al., 2003), it is imperative they are well informed regarding signs of poor mental health among older adults and appropriate treatment options available. As illustrated in some participants' experiences seeking help for their mental health problems, when they disclosed to their primary care physician and were then referred immediately to a psychologist, their pathway to care was fairly direct and efficient. Participants who were able to receive psychological treatment when they first began experiencing a decline in their mental health also described noticing a fairly immediate improvement in their mental health and well-being. Therefore, it is important for older adults to receive accessible psychological treatment prior to their symptoms becoming more severe and chronic, and more difficult to treat.

Although it is imperative that primary care physicians are well informed of appropriate treatment options for mental health problems, a third factor that advanced help-seeking was older adults' previous knowledge of mental health and treatment options. Research suggests that good mental health literacy may lead to better outcomes for individuals with mental health problems by facilitating early help-seeking (Jorm et al., 1997). In line with this, participants in this study who had previous positive experiences with psychologists or participants who were informed about the types of treatment psychologists offered, had a more direct pathway to psychological care. This, in part, was due to participants knowing what type of referral to ask for from their primary care physician, as opposed to them relying on their physician to make the appropriate referral. Knowing what type of treatment they would like and expressing their preferences to

their primary care physician appeared to greatly reduce the delays and barriers in receiving psychological care. Unfortunately, research suggests that older adults have poorer mental health literacy in comparison to young adults (Farrer et al., 2008; Fisher & Goldney, 2003). Therefore, as previously mentioned, it is important to ensure older adults are informed about mental health problems and treatment options available, to facilitate a more seamless pathway into psychological care.

Complexity of Help-seeking

Despite the general factors that advanced and delayed help-seeking in my sample of older adults, these factors not only varied among individuals, but also within individuals at different times of their illness careers, which speaks to the complex and dynamic nature of help-seeking. What makes help-seeking so complex is that it is a socially embedded process that is tied not only to individuals with mental health problems but also to the communities in which they live, the social network members who surround them, and those who they encounter in the treatment system (Pescosolido & Boyer, 2010). To illustrate this, dynamic models like the NEM-II (Pescosolido & Boyer, 2010; Pescosolido et al., 2013) have been developed to challenge the underlying, rational choice assumption of traditional utilization models (Andersen, 1995; Goldsmith et al., 1988; Maddux & DuCharme, 1997; Parsons, 1951; Strecher et al., 1997; Vogel et al., 2006). Reconsidering the rational choice assumption has expanded the way researchers and clinicians consider and conceptualize other pathways into care (Pescosolido & Boyer, 2010; Pescosolido et al., 2013), to better reflect the diversity across and within individuals' experiences seeking help and utilizing mental health services. Given the socially embedded nature of help-seeking, it will be worthwhile for future research to examine how the opinions and beliefs held

by social and treatment network members affect how individuals consider their options for care and the effect this has on service use.

Limitations

Although qualitative research allows investigators to acquire rich data from the perspective of the individuals in the study, there are several limitations of which to be mindful. First, I recruited a sample of older adults from a specific treatment facility in a specific geographical location. So whereas each participant in this study had accessed specialty mental health services, only a small percentage of older adults in the general population receive treatment by specialized mental health professionals (Bartels & Drake, 2005; George et al., 1988; Mackenzie et al., 2010). Therefore, the experiences of the participants in this study are only capturing “successful stories” into the formal treatment system. Moreover, I did not capture older adults whose primary care physicians did not recognize their mental health problem(s) and/or did not refer on to geropsychologists. As such, the results may not transfer to older adults in other settings receiving different treatments. To mitigate this concern, I provided detailed information about the demographic profile of the current sample to help readers determine the transferability of the current results to other samples. In line with this, it is also important to note that just under half of the participants in my sample reported low levels (scores of 0-7) of emotional distress (Kessler et al., 2003, Wang et al., 2007). There are at least two potential explanations for this. First, given that they were patients receiving psychotherapy for mental health problems, perhaps the therapy they had received up to the point of the interview had a positive impact at reducing their level of emotional distress. Indeed, approximately one quarter of participants indicated that they were nearing the end or completed treatment. Second, it may be that participants' low levels of emotional symptoms are reflective of subsyndromal mental

health problems. Research suggests that whereas older adults are less likely to meet full criteria for anxiety and mood disorders, they are more likely to have subsyndromal mental health concerns (Blazer, 1991; Cui, Lyness, Tang, Tu, & Conwell, 2008; Himmelfarb & Murrell, 1984; Vahia et al., 2010). Therefore, in order to capture older adults' diverse mental health experiences and various pathways to care, it will be important to recruit a broad range of individuals with varying degrees of distress in future studies. Third, another limitation of this study is the risk of selection bias in the sample. It is possible that the experiences of individuals who did not wish to participate in this study were different from the individuals who agreed to participate. Fourth, two participants requested to have their spouses sit in on the interview, which may have influenced what the participants felt comfortable discussing, thereby biasing their responses. It is not uncommon in qualitative research for participants to request that family members sit in on the interview and it is therefore important for the interviewer to be clear with the additional family member about the level of participation permissible (King & Horrocks, 2010). As such, I explained to the participants and their spouses that the purpose of the interview was to gather information only about the participant's experience seeking psychological care for their mental health problem(s) and I confirmed with the participants, prior to the interview, that they were comfortable discussing this information in front of their spouses. Fifth, another potential limitation is that this study focused primarily on individual factors (e.g., perceived need for care, mental health literacy, financial concerns, etc.) and did not capture larger environmental and structural barriers to treatment. Lastly, given that the majority of participants were either just beginning, part way through, or nearing the end of psychological treatment at the time of being interviewed, I was unable to capture key exits from participants' illness careers, as identified in the NEM-II (Pescosolido et al., 2013). Despite these limitations,

this study provided rich data about older adults' experiences seeking psychological services.

Implications and Conclusions

Older adults are especially unlikely to seek professional help for mental health problems that can be severe, complex, and chronic (Byers et al., 2012; Cairney et al., 2010; Karlin et al., 2008; Mackenzie et al., 2010; Mackenzie et al., 2012; Mosier et al., 2010), which is a growing public health concern given population growth and aging (Statistics Canada, 2011). To progress, research must first take a step backward and re-evaluate what is known about the dynamics of mental health service use and where further theorizing and research are required (Pescosolido et al., 2013). Findings from this study suggest that the NEM-II is an appropriate and advantageous service use model to use with an older adult sample because it challenges both the rational choice logic and voluntary tone of dominant help-seeking and service utilization models, thereby making room for other possible pathways to care. Additionally, the NEM-II has advanced more complex notions of mental health service use by focusing not only on a variety of service configurations but also on the influence of an individual's social context, social support system, and treatment system on the illness career, and the dynamic relationship between these factors (Pescosolido & Boyer, 2010; Pescosolido et al., 2013). Therefore, this model is ideally suited for use within an older adult population because their experiences with mental health problems and service use can be complex due to the high likelihood of comorbid mental and physical disorders (Bartels & Naslund, 2013; Bartels & Smyer, 2002; El-Gabalawy et al., 2011; El-Gabalawy et al., 2014) and their low rates of service use (Byers et al., 2012; Cairney et al., 2010; Karlin et al., 2008; Mackenzie et al., 2010; Mackenzie et al., 2012; Mosier et al., 2010). Additionally, despite older adults' preference for psychological treatments for mental health problems (Gum et al., 2006; Wetherell et al., 2004), they are increasingly prescribed psychotropic medications despite

the known risks associated with drug interactions and an increase in falls (Hines & Murphy, 2011; Schellander & Donnerer, 2009; Vieweg et al., 2009; Woolcott et al., 2009). For these reasons it is imperative that researchers in the mental health field have a thorough understanding of the dynamic factors that contribute to the underutilization of psychological treatments among older adults in order to begin to develop solutions to address it.

In summary, based on the experiences from older adults in this study, factors that delayed participants' pathway to care included: a lack of support, "inappropriate" referrals or advice from treatment professionals, and a lack of knowledge about mental health and treatment options available. In contrast, factors that advanced participants' pathways to care included: support from certain members of their social network, treatment professionals who identified mental health problems among participants early and made referrals that met their needs, and participants with higher levels of mental health literacy. Overall, this qualitative study has important implications for better understanding the dynamic and complex relationships between older adults' background (social content), their illness career, social support system, and treatment system. This information adds significantly to the mental health and service utilization literature that largely focuses on correlates of service use by capturing rich details about the dynamic nature of help-seeking and service use among older adults. Additionally, findings from this study will likely generate hypotheses that future quantitative researchers can test regarding the help-seeking process. Most importantly, this knowledge will inform researchers, clinicians, and perhaps even public policy initiatives aimed at enhancing older adults access to psychological treatment.

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Table 1
Sample Characteristics

| Characteristics | <i>n</i> | % | | |
|---|--------------|----------|-----------|--|
| Gender | | | | |
| Males | 5 | 33.3 | | |
| Females | 10 | 66.7 | | |
| Ethnicity | | | | |
| White | 14 | 93.3 | | |
| Filipino | 1 | 6.7 | | |
| Marital Status | | | | |
| Married/ Common Law | 13 | 86.7 | | |
| Widowed | 2 | 13.3 | | |
| Highest Level of Education | | | | |
| Grade 12 | 6 | 40.0 | | |
| Undergraduate degree | 5 | 33.3 | | |
| Nursing degree | 1 | 6.7 | | |
| Master's degree | 3 | 20.0 | | |
| Occupational Status | | | | |
| Retired | 13 | 86.7 | | |
| Part-time | 2 | 13.3 | | |
| Estimated Annual Household Income | | | | |
| Under \$25,000 | 2 | 15.4 | | |
| \$25,000-\$50,000 | 5 | 38.5 | | |
| \$50,000-\$75,000 | 2 | 15.4 | | |
| Over \$75,000 | 4 | 30.8 | | |
| Previously Diagnosed with a Mental Health Problem | | | | |
| Mood Disorder | 4 | 57.1 | | |
| Anxiety | 3 | 42.9 | | |
| | <i>Range</i> | <i>M</i> | <i>SD</i> | |
| Age | 63-87 | 72.3 | 6.6 | |

Note. N=15.

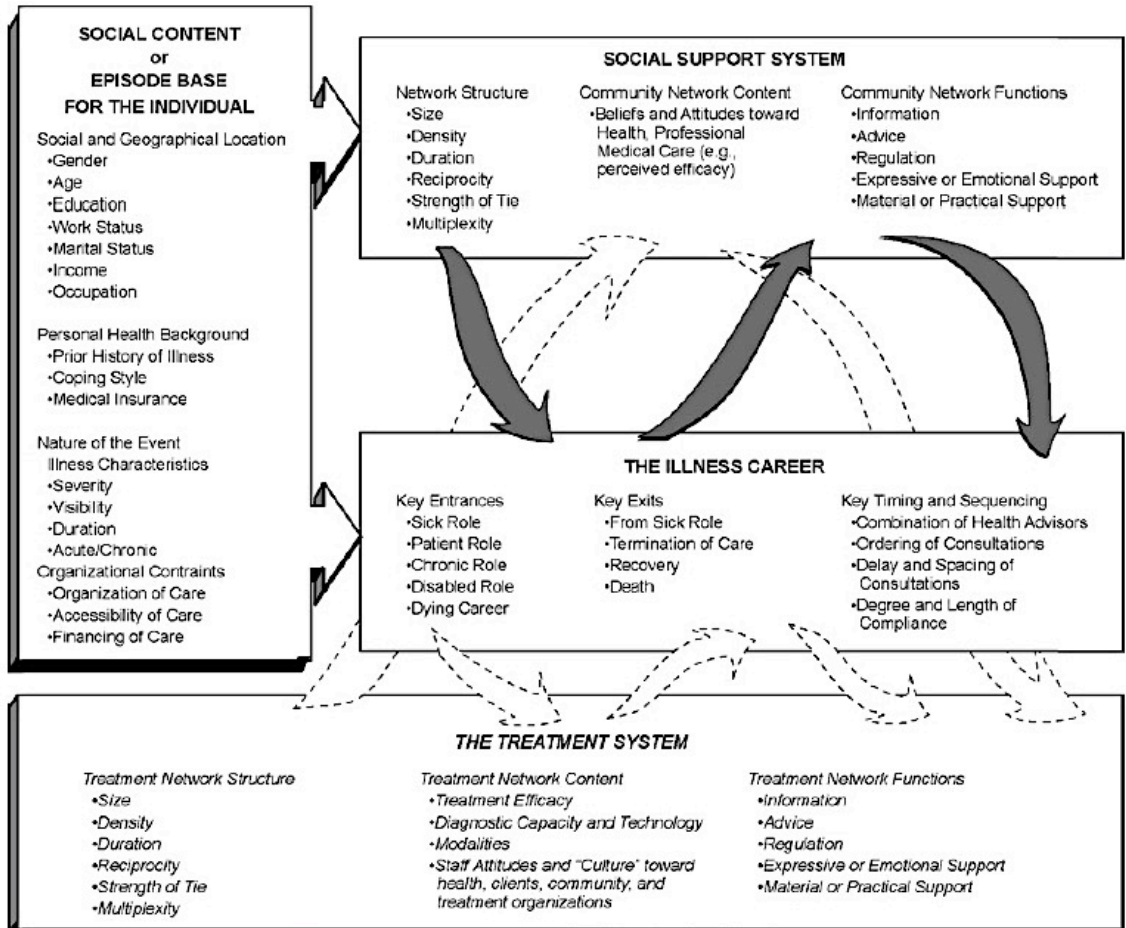


Figure 1. The network-episode model II developed by Pescosolido et al., 2013.

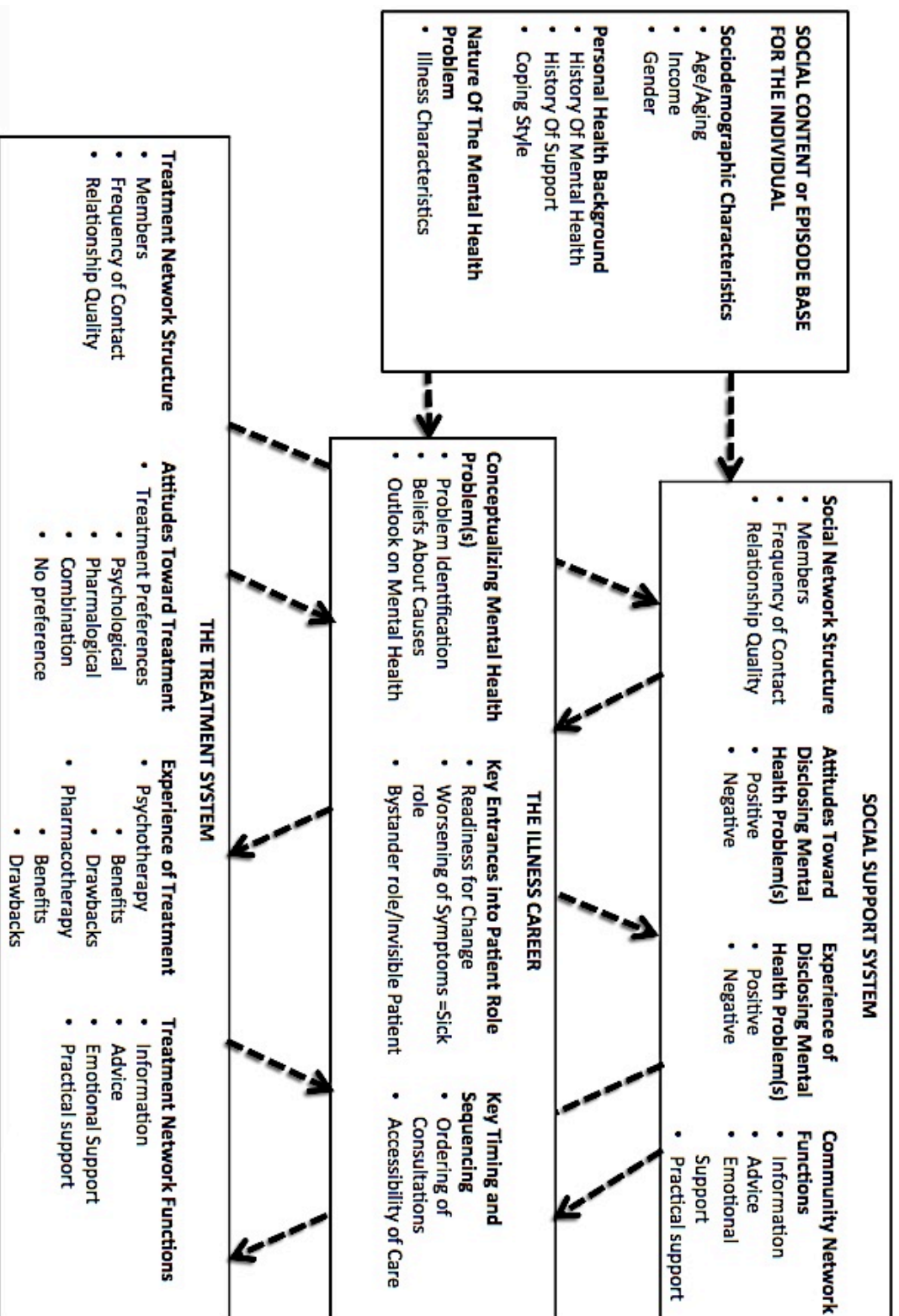


Figure 2. Themes and subthemes emerging from interviews.

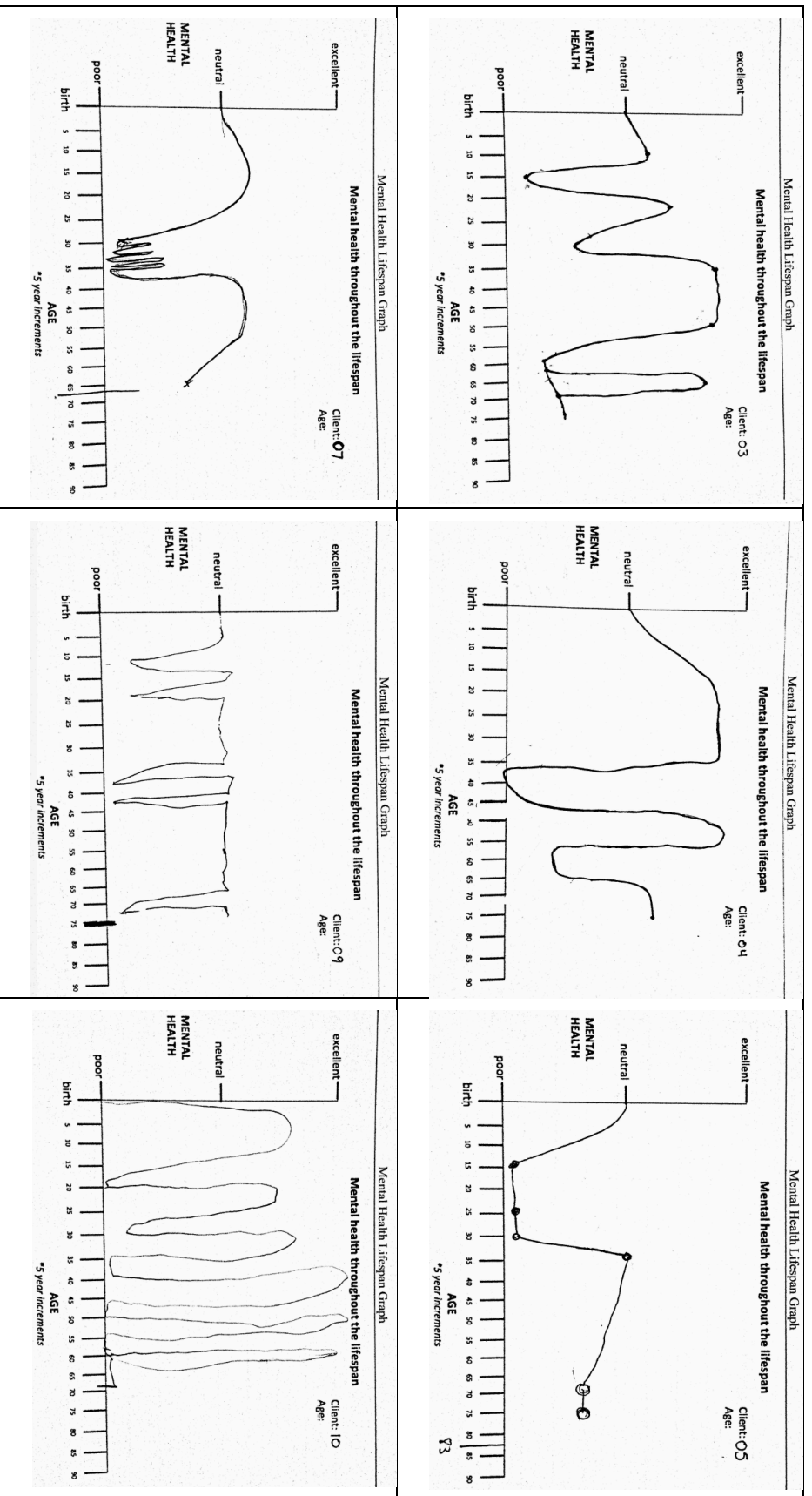


Figure 3. Mental health across the lifespan: 'Chronically emotionally unwell' examples.

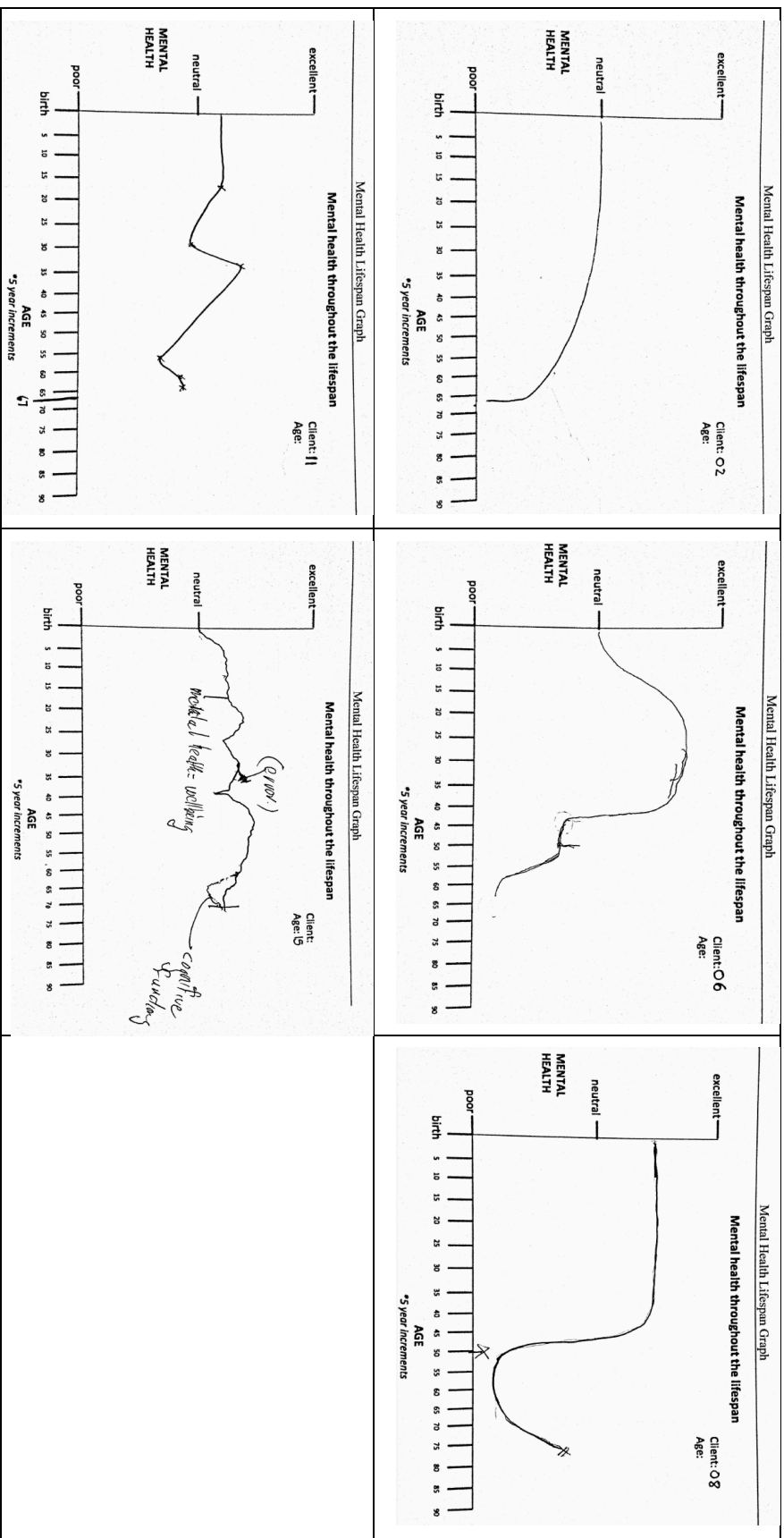


Figure 4. Mental health across the lifespan: 'Late-life first onset' examples.

Appendix A

Script: Recruitment at St. Boniface Hospital

Description of script: Clinical geropsychologists at St. Boniface Hospital, will read the following description of the research study to their clients who meet my inclusion criteria (e.g., 60 years and older, fluent in English, and no noticeable cognitive impairment).

Hello [client name],

Brooke Beatie, a Master's student in clinical psychology at the University of Manitoba, is conducting a research study looking at peoples' experiences seeking treatment for mental health problems. You are eligible to participate in this research study. Participation in this study involves sitting down with Ms. Beatie for an hour-long interview. The interview will be audio-recorded, and can be completed in your home, here at the St. Boniface Hospital, or at the University of Manitoba. During the interview, Ms. Beatie will ask you questions about what you think caused X [mental health problem that clients are in treatment for] and about your treatment preferences. Ms. Beatie will give you a \$10 gift card to a coffee shop or grocery store as a thank you for your time. I want to emphasize that your participation in this research study is in no way linked to the treatment that you are receiving at St. Boniface Hospital. I will not know whether you ultimately decide to participate in this study or not. Whether you decide to participate or not participate in this research study, your treatment will not be affected. Does this seem like something that you are interested in learning more about? [If no, the geropsychologists will thank their clients for the time they took to listen to this information].

[If yes]

Since you are interested in learning more about this study, can I give Ms. Beatie your name and telephone number so that she can contact you to discuss this study in more detail and arrange an individual interview, if you decide to participate? [If participants do not want to give their name and telephone number, the geropsychologists will give clients Ms. Beatie's contact information if they would prefer to contact her].

[If yes, the geropsychologists will obtain signed consent to release patient's contact information]

Thank you very much. Ms. Beatie will be in touch with you shortly.

[The geropsychologists will leave potential participants' signed consent forms in a file folder that will be kept in a locked filing cabinet on the 4th floor of the McEwen Building].



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Consent to Release Contact Information

Navigating Pathways to Care: Exploring Older Adults' Experience Seeking Psychological Care

Principal Investigator: Brooke Beatie, B.A. (Hons), Department of Psychology, University of Manitoba, Ph. (204) XXX-XXXX/ umbeatie@myumanitoba.ca

Research Supervisor: Dr. Corey Mackenzie, Ph.D., C. Psych., Associate Professor, and Director of Clinical Training, Department of Psychology, University of Manitoba
Ph. (204) 474-8260/ corey.mackenzie@umanitoba.ca

Purpose:

Brooke Beatie is conducting this study as part of her Master's Thesis, under the supervision of Dr. Mackenzie. The purpose of this research is to better understand how your beliefs about causes of mental health problems and treatment preferences influence your pathways to care.

Consent to release contact information:

You indicated that you are interested in learning more about this study. Whether you decide to participate or not participate in this research study, your treatment will not be affected. If you decide to participate, your participation is in no way linked to the treatment that you are receiving at St. Boniface Hospital. The researchers will not share the identity of participants with any psychologists or service provider at St. Boniface General Hospital or elsewhere. Only the principal investigator, her supervisor, and members of Dr. Mackenzie's Aging and Mental Health laboratory will have access to the data. The information that you provide will be de-identified and kept in a secure location on password-protected computers and in a locked cabinet at the Aging and Mental Health Research Laboratory at the University of Manitoba. Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. The plans for dissemination are to present group-level (not individual-level) results at seminars, conferences, and to submit the findings for publication in a peer-reviewed publication.

Do I have your permission to give Ms. Beatie your name and telephone number so that she can contact you to discuss this study in more detail?

- No
- Yes

If YES, please provide your name and telephone number:

Name: _____

Telephone number: _____

Signature: _____

Date: _____

Appendix B

Telephone Recruitment Statement

Description of recruitment statement: I [Brooke Beatie] will introduce myself and briefly go over the details of this study. After I have discussed this study and answered any questions the potential participant may have, I will ask if they are interested in participating in this study. If they are interested in participating, I will schedule a meeting time and location to conduct my interview with them.

Hello [client name],

My name is Brooke Beatie; I am a Master's student in clinical psychology at the University of Manitoba. I am calling you because you indicated to Dr. X that you would like to learn more about this study. Is this a good time to tell you more about it?

[If no]

If you are still interested to learn more about it, is there a better time I should call you back?

No: Thank you for your time. Have a nice day.

Yes: Ok, I will give you a call then [time they request to be called back]. Thanks!

[If yes]

This research study is looking at peoples' experiences seeking treatment for mental health problems. Participation in this study involves sitting down with me for a semi-structured individual interview. I will ask you questions about what you think caused X [mental health problem that clients are in treatment for] and about your treatment preferences.

Your participation in this study is completely voluntary. Should you choose to withdraw from the study at any point or feel that you would rather leave some question(s) unanswered, you may do so.

Prior to taking part in the interview, you will complete a brief questionnaire focusing on your background (i.e., your age, your ethnicity, marital status etc.) and health status. During the interview, you will be asked questions about your experience with mental health problems, your beliefs about causes of your mental health problems, treatment preferences, and social support. It will take approximately 1 hour to complete the interview. You will receive a \$10.00 gift card to a local coffee shop or grocery store as a thank you for your participation in this study.

Before I continue telling you more about this study, did you have any questions so far?

No: Ok.

Yes: [I will answer any questions they have thus far.] Now I'll finish telling you about this study.

After I have completed all of my interviews, I will contact you again to invite you to meet with me for a follow-up interview. The purpose of this second interview is to discuss my interpretation of my interviews to ensure I have an accurate description of your experiences. The follow-up interview should take approximately 30 minutes. If, at the end of the first interview, you decide that you would not like the information you've provided to be used in this study, please let me know and I will remove it from my analysis.

Your interview will be audio-recorded, and will be completed privately in a location of your choice, which may include your home, at the McEwen Building at St. Boniface Hospital, or at the University of Manitoba.

Your participation in this research study is in no way linked to the treatment that you are receiving at St. Boniface Hospital. I will not disclose to your doctor whether you decide to participate in this study or not. Whether you decide to participate or not, your treatment will not be affected.

Did you have any questions?

No: Ok.

Yes: [I will answer any questions they have thus far.]

Would you like to participate in this study?

[If no]

Thank you for your time. Have a nice day.

[If yes]

Where would you like the interview to take place?

Home

Address: _____

St. Boniface

University of Manitoba?

What day/time is best for you?

Date: _____

Time: _____

Thank you for your time. If you need to cancel or reschedule our meeting, please do not hesitate to call me at (204) XXX-XXXX. I look forward to seeing you on [meeting date/time].

Appendix C

Background & Health Information

Today's Date: _____

Age: _____

Born in Canada? Yes _____ No _____ (If no, # of years living in Canada: _____)

Highest level of education: _____

Current occupational status:

Full-time Part-time Retired, from what:

Other: -

If you are currently retired, how long have you been retired? _____

Marital status: Single Common law Married Widowed Divorced
 Separated

Estimated annual household income:

Under \$25,000 \$25,000 - \$50,000 \$50,000 - \$75,000 Over \$75,000

Race/Ethnicity:

| | |
|-----------------------------------|-------------------------------------|
| _____ White | _____ Aboriginal/First Nations |
| _____ Black | _____ Middle Eastern |
| _____ Indian/Pakistani/Sri Lankan | _____ Hispanic/Latino |
| _____ Japanese/Korean/Chinese | _____ Filipino/Malaysian/Indonesian |
| Other: | |

Health Information

In general, how would you describe your overall health:

Excellent Very Good Good Fair Poor

Have you been diagnosed with a mental health problem?

Yes No

If YES, what mental health problem(s) have you been diagnosed with?

Have you seen a variety of professionals over the years for mental health problems?

Yes No

If YES, who have these people been?

Do you have extended health insurance coverage – a plan that covers services such as ambulance, physiotherapy, and other health services not covered by Manitoba Health?

Yes No Not sure

If YES, does your extended health insurance plan cover the cost of medications prescribed by a doctor?

Yes No Not sure

Does your extended health insurance plan cover psychology services?

Yes No Not sure

Approximately where are you at the moment in terms of your current mental health treatment as St. Boniface?

- Haven't started yet
- I just started
- I'm part way through
- Nearing the end
- Completed treatment

Have you been diagnosed with a chronic disease (i.e., diabetes, arthritis, chronic pain, bowel disease, etc.)?

Yes No

If YES: What chronic disease(s) were you diagnosed with?

| Chronic Disease | Year Diagnosed |
|-----------------|----------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |

Approximately how many different medications are you taking?

For what purpose, if you know? (I.e., physical illness, sleep, nervousness, etc.)

How optimistic are you regarding your treatment at St. Boniface hospital on a scale from 0

(not optimistic at all) and 10 (very optimistic)?

Please circle:

1 2 3 4 5 6 7 8 9 10

FAMILY: Considering the people to whom you are related either by birth or marriage,

1. How many relatives do you see or hear from at least once a month?

0 = none 1 = one 2 = two 3 = three or four 4 = five thru eight 5 = nine or more

2. How many relatives do you feel close to such that you could call on them for help?

0 = none 1 = one 2 = two 3 = three or four 4 = five thru eight 5 = nine or more

3. How many relatives do you feel at ease with that you can talk about private matters?

0 = none 1 = one 2 = two 3 = three or four 4 = five thru eight 5 = nine or more

FRIENDSHIPS: Considering all of your friends including those who live in your neighborhood,

4. How many of your friends do you see or hear from at least once a month?

0 = none 1 = one 2 = two 3 = three or four 4 = five thru eight 5 = nine or more

5. How many friends do you feel close to such that you could call on them for help?

0 = none 1 = one 2 = two 3 = three or four 4 = five thru eight 5 = nine or more

6. How many friends do you feel at ease with that you can talk about private matters?

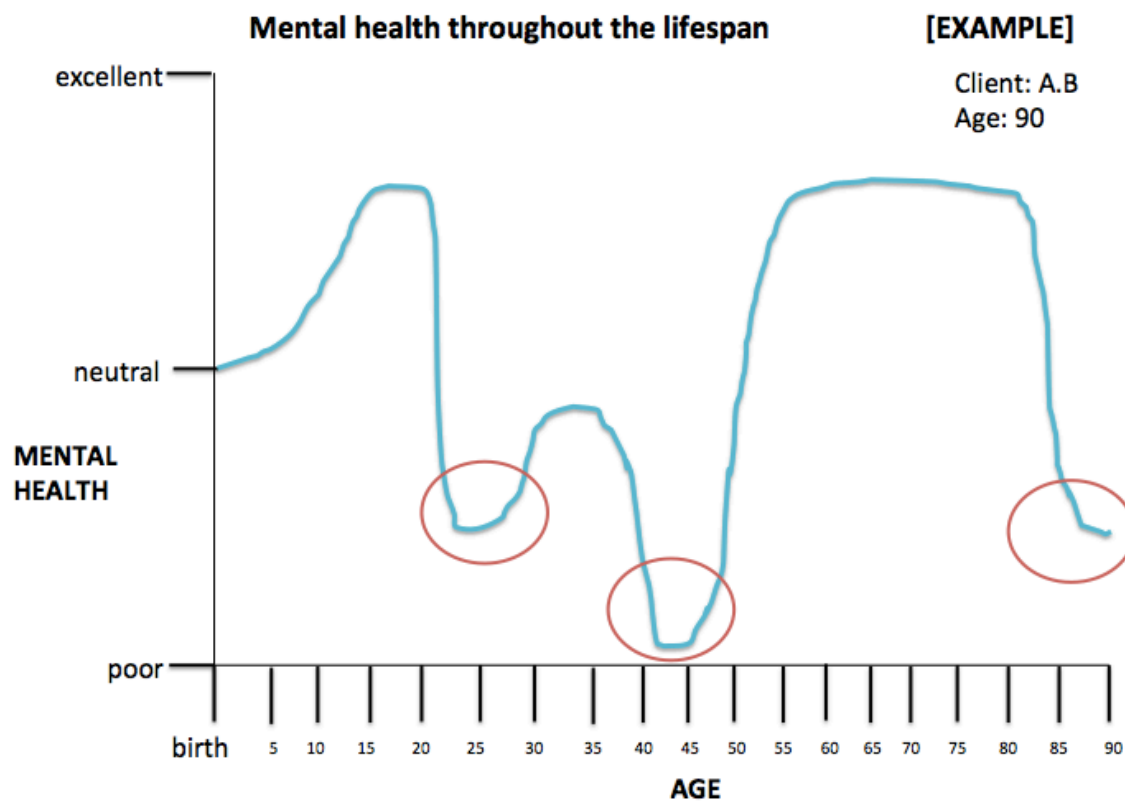
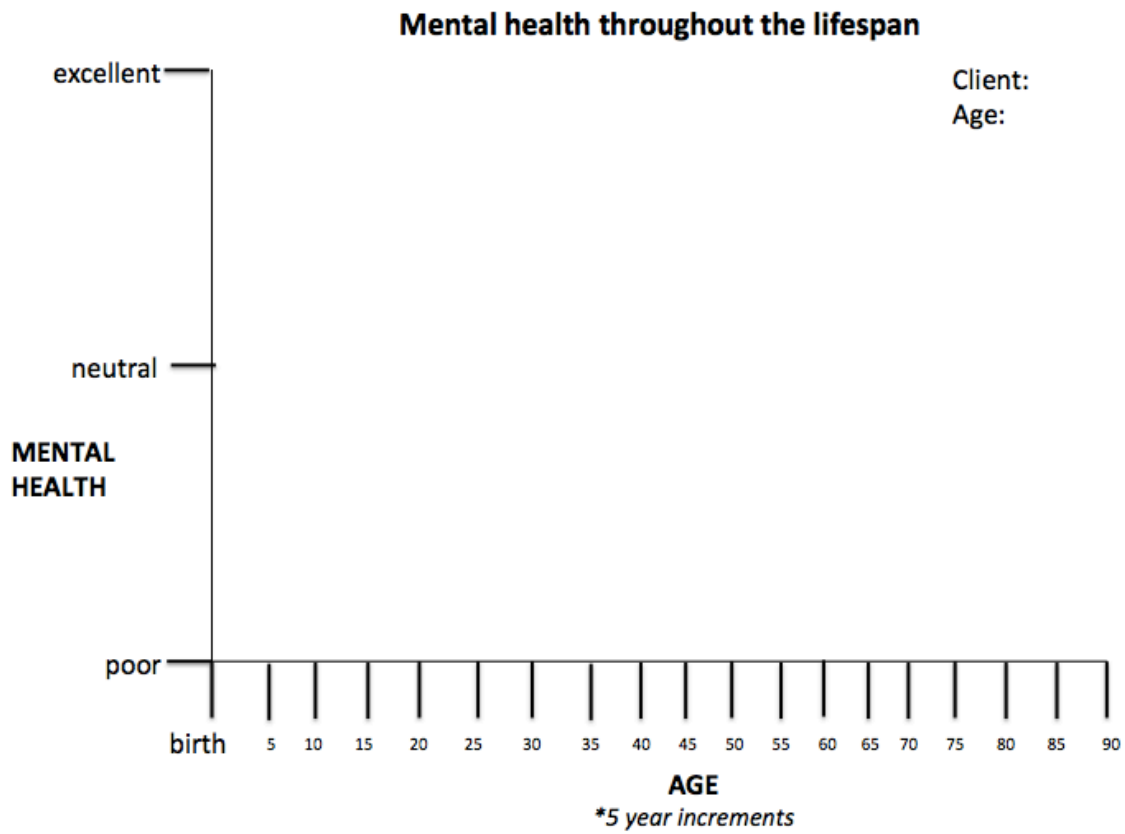
0 = none 1 = one 2 = two 3 = three or four 4 = five thru eight 5 = nine or more

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please mark the rating that best describes how often you had this feeling.

| During the past 30 days, about how often did you feel ... | All of the time (1) | Most of the time (2) | Some of the time (3) | A little of the time (4) | None of the time (5) |
|--|---------------------------|----------------------------|----------------------------|--------------------------------|----------------------------|
| 1. ...nervous? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. ...hopeless? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. ...restless or fidgety? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. ...so depressed that nothing could cheer you up? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. ...that everything was an effort? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. ...worthless? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Appendix D

Mental Health Lifespan Graph



Appendix E

Interview Protocol

**Ask participants to complete mental health lifespan graph at beginning of interview & use this as a discussion tool during the second half of the interview regarding past experience. (Please see Appendix B).*

CURRENT EXPERIENCE

Illness career (10mins)

1. What brings you in for treatment at St. Boniface Hospital?

- a. What would you say is your primary concern that you are hoping to get help for?
 - i. Do you have other concerns that are contributing to X [mental health problem that clients are in treatment for]?
- b. How severe would you say this [X] is?
- c. How long has this been going on for?
- d. ~~REMOVED: Acute/chronic: Is this a reoccurring problem or is this something new that's been occurring?~~

2. How would you describe your path into treatment for X [mental health problem that clients are in treatment for]? (Probe for active, coerced, confusing: For example, did you actively seek out treatment, did you feel forced into treatment by others, or was your experience getting into treatment confusing?)

Social (family, friends, lay persons) (10mins)

If you think about your family, friends, neighbours...those in your social network...

3. Was there anyone who helped you to recognize that you needed help and helped you to find help? (Probe for personal, familial, and systemic factors)

4. **Was there anyone who was unhelpful in this process?** (Probe for personal, familial, and systemic obstacles/challenges)

Cultural (attitudes, beliefs, values) (10mins)

5. **What do you think caused X [mental health problem that clients are in treatment for]?**
 - a. What do you think the primary cause of this is (environmental, psychological, biological)?
6. **In terms of what you think caused X, I'm wondering what has influenced your thoughts on that?** (Probe for personal, familial, and service provider influences; e.g., Are there people in your life that have helped you come to that or things you've read?)
7. **ADDED: Has religion helped you cope with things and if so, how has it helped?**

Organizational (medical, service agencies, health care providers, treatment) (10 mins)

8. **Did you have a treatment preference for X [mental health problem that clients are in treatment for]?**
 - a. Did you receive your preferred treatment?
 - i. If no, what barriers did you encounter?
9. **What are the benefits and/or drawbacks you experienced from receiving treatment?**
- ~~10. REMOVED: I see that you indicated your primary health care provider is _____ (refer to questionnaire), have you talked to _____ (primary health provider) about X [mental health problem that clients are in treatment for]?~~
 - ~~b. Was _____ (primary health provider) helpful to you?~~
11. **Are there any other professionals you are seeing for services regarding X [mental health problem that clients are in treatment for]?**

- c. How are these other professionals helping you?
- d. What treatments are you getting?

PAST EXPERIENCE

Dialogue: *Let me ask you about your past experience with mental health problems...*

Illness career (5 mins)

12. Can you now give me a sense of your mental health over your lifetime? (use graph as tool)

- a. What has contributed to your mental health worsening (use low points depicted in their graph)?
- b. What helped you get better (use high points depicted in their graph)?

Social (family, friends, lay persons) (5 mins)

When you look at this graph, throughout your life...

13 ADDED: Did you feel supported by your parents, family, and or friends?

- a. Were there people who helped you to recognize that you needed help and helped you to find help? (Probe for personal, familial, and systemic factors)
- b. Was there anyone who was unhelpful in this process? (Probe for personal, familial, and systemic obstacles/challenges)

Cultural (attitudes, beliefs, values) (5 mins)

14 You told me above that the primary cause of your current problem is _____.

Did you have similar beliefs about the cause of these earlier episodes, or has that changed? (Utilize graph)

Organization (medical, service agencies, health care providers, treatment) (5 mins)

15 Have your treatment preferences changed over time? (Utilize graph)

- a. If yes, who/what contributed to your treatment preferences changing?

16 Have there been other times in your life when you would have liked to see someone (psychologist/psychiatrist/social worker) but didn't?

Conclusion:

17 Is there anything about your experience that we haven't covered that you wish to speak about?

Appendix G



Hôpital St-Boniface Hospital

UNIVERSITY
OF MANITOBA**Informed Consent Form**

Navigating Pathways to Care: Exploring Older Adults' Experience Seeking Psychological Care

Principal Investigator: Brooke Beatie, B.A. (Hons), Department of Psychology, University of Manitoba, Ph. (204)xxx-xxxx/ umbeatie@myumanitoba.ca

Research Supervisor: Dr. Corey Mackenzie, Ph.D., C. Psych., Associate Professor, and Director of Clinical Training, Department of Psychology, University of Manitoba
Ph. (204) 474-8260/ corey.mackenzie@umanitoba.ca

This consent form, a copy of which you may keep for your records, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please take your time to review this consent form and discuss any questions you may have with the researcher. Please take the time to read this carefully and to understand any accompanying information. If there is something that you do not understand, please ask the researcher to explain any words or information that you do not clearly understand.

Purpose:

Brooke Beatie is conducting this study as part of her Master's Thesis, under the supervision of Dr. Mackenzie. The purpose of this research is to better understand how your beliefs about causes of mental health problems and treatment preferences influence your pathways to care. This study will inform researchers, clinicians, and public policy initiatives aimed at enhancing access to care and in turn, increase older adults' ability to make informed treatment choices.

Participation:

Your participation in this study is completely voluntary. Should you choose to withdraw from the study at any point or feel that you would rather leave some question(s) unanswered, you may do so.

If you decide to participate in this study, you will participate in an interview conducted by the principle investigator, Brooke Beatie. Prior to taking part in the interview, you will complete a brief questionnaire focusing on your background (i.e., your age, your ethnicity, marital status etc.) and health status. During the interview, you will be asked questions about your experience with mental health problems, your beliefs about causes of your mental health problems,

treatment preferences, and social support. It will take approximately 1 hour to complete the interview. After I have completed all of my interviews, I will contact you again to schedule a brief follow-up interview. The purpose of this second interview is to discuss my interpretation of your interview to ensure I have an accurate description of your experience. The follow-up interview should take approximately 30 minutes. You will receive a \$10.00 gift card to a local coffee shop or grocery store as a thank you for your participation in this study. If, at the end of the first interview, you decide that you would not like the data you've provided to be used in this study, please inform the researcher.

Legal Rights:

Your decision to participate does not waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities.

Results:

The summary results of this study (not your individual results, which will never be shared) should be available by August 2016. If you would like to receive a summary of the results, please provide your contact information below.

Confidentiality:

Only the principal investigator, her supervisor, and members of Dr. Mackenzie's Aging and Mental Health laboratory will have access to the data. The information that you provide will be de-identified and kept in a secure location on password-protected computers and in a locked cabinet at the Aging and Mental Health Research Laboratory at the University of Manitoba. The researchers will not share the identity of participants with any psychologists or service provider at St. Boniface General Hospital or elsewhere. Whether you decide to participate or not participate in this research study, your treatment received at St. Boniface Hospital will not be affected. Medical records that contain your identity will be treated as confidential in accordance with the Personal Health Information Act of Manitoba. Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. The plans for dissemination are to present group-level (not individual-level) results at seminars, conferences, and to submit the findings for publication in a peer-reviewed publication. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed.

Limits to confidentiality:

If you disclose information that you are an imminent threat to someone else or to yourself, we are required to break confidentiality to ensure the safety of the person at risk. If you disclose information that a child or other vulnerable person is being abused or neglected, we are required to break confidentiality and report the information to the appropriate authority.

Benefits:

Although this study will have no direct benefits for you, we hope the information learned from this study will be used to enhance older adults' access to mental health services when they need them.

Risks:

You will be asked to provide information that you could find difficult or distressing to recall and to talk about. You might also become distressed after participating in this study. If you are distressed you can stop at any time without consequence. We will also provide you with a list of mental health resources or service providers should you need to talk with someone.

University approval:

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at (204) 474-7122.

Security:

All questionnaire and interview data will be stored on password-protected laboratory computers and in locked filing cabinets at the Aging and Mental Health Laboratory at the University of Manitoba. University administrators may check the data to see that the research has been ethically done. The University of Manitoba Psychology/Sociology Research Ethics Board and St. Boniface Hospital may review research-related records for quality assurance purposes.

Contact:

If you have any additional questions about this study or your rights as a research participant, please feel free to contact the principal investigator, Brooke Beatie, graduate student in Clinical Psychology, University of Manitoba. You may also contact Ms. Beatie's supervisor, Dr. Corey Mackenzie. Contact information for these individuals can be found at the top of this form.

Statement of Consent:

I have read this consent form and I understand my role as a participant. I have had the opportunity to discuss this study with Brooke Beatie and I have had my questions answered. The risks and benefits have been explained to me. I have not been influenced by any study team member to participate in the study by any statements or implied statements. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I permit the inspection of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant signature: _____

Participant printed name: _____

Date _____
(day/month/year)

Permission for future contact: I agree to be contacted by Ms. Brooke Beatie by telephone, mail, or email for future follow-up in relation to this study, if any of the content from the individual interview is unclear to her.

Yes No Participant Initials _____ Telephone: _____

Email: _____

Would you like to receive a summary of the results of this study?

No

Yes, I would like to receive the summary results.

If yes, please provide your contact information below:

Email: _____

Phone number: _____

Would you like to be contacted for future studies?

No

Yes, I would like to be contacted for future studies.

If yes, please provide your contact information below:

Email: _____

Phone number: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____

Date: _____

Signature: _____

Role in the study: _____

Mental Health Resources and Service Providers

Websites:

- Canadian Mental Health Association
WINNIPEG REGION: **www.cmhawpg.mb.ca**
- Mood Disorders Association of Manitoba
www.depression.mb.ca
- Anxiety Disorders Association of Manitoba
www.adam.mb.ca

Telephone numbers:

- Winnipeg Regional Health: Mobile Crisis Service
(204-940-1781)
- Mental Health Education and Resource Centre
(204-942-6568) or (1-855-942-6568)

Service Agencies:

The service agencies listed below provide no cost or low cost services

- **KLINIC COMMUNITY DROP-IN COUNSELLING SERVICE**
Drop-in counselling is available at two locations in Winnipeg. Call for locations and times **(204-784-4067)** or visit www.klinic.mb.ca and go to “counselling services.”
- **FAMILY AND FRIENDS** - Support group sponsored by the Mood Disorders Association of Manitoba.
(204-786-0987)

****For a more extensive list of mental health resources and services please visit:
http://www.cmhawpg.mb.ca/documents/CMHAGuide-Ed16-WEBJune_000.pdf**