

EXPLORATION OF HELP-SEEKING GERIATRIC POPULATION

Choice, Coercion, and/or Muddling Through:

An Exploration of Older Manitobans' Experiences Seeking Psychological Care

by

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## Abstract

In any given year, approximately 20% of Canadians suffer from mental health problems, and treatment-seeking has been shown to be least likely in older adults. Although decades of research have been devoted to help-seeking behaviors, barriers to accessing treatment, and service utilization models, reasons why many older adults with mental health problems do not seek professional help are not fully understood. Theoretical models can be helpful in improving our understanding of why people do or do not seek help, and the Network Episode Model (NEM) (Pescosolido et al., 1998) suggests that there are three unique pathways into treatment: choice (willingness), coercion (force or pressure) or muddling through (either ‘drifting around’ between services, or having someone other than the client take over the help-seeking journey). This study aimed to capture the dynamic process of older Canadians’ help-seeking pathways, in order to better understand the experiences of clients from their initial mental health concerns, through to a clinical psychologist’s office. The current study examined two objectives: 1) classifying older Manitobans’ pathways into treatment according to the NEM, and 2) exploring whether the pathways should represent distinct treatment journeys (i.e., choice, coercion, *or* muddling through), or if they are best conceptualized as co-occurring processes (i.e., choice, coercion, *and* muddling through). Utilizing secondary qualitative data from three previous studies ( $N = 35$ ), objective one was examined using directed content analysis, to classify older Manitobans’ pathways into treatment using the NEM. Participants’ sought help for a variety of reasons, including anxiety and mood disorders, coping with life stressors and physical illness, and caregiver stress. Findings highlight that the majority ( $n=21$ , 60%) of the sample entered care choicefully (willingly accessing treatment), with 42.9% of that group involving ‘others’ in their treatment-seeking, by way of referrals, advise, or support. The remaining participants ( $n = 14$ , 40%) entered care through the muddling pathway. No participants’ pathways were primarily categorized as coercive. For the second objective, conventional content analysis was used to explore how best to categorize pathway journeys. Findings demonstrated that few participants ( $n = 10$ , 28.6%) had a help-

seeking journey that represented only one type of pathway. A period of muddling through was included in all but two participants' journeys to care, and muddling often preceded choice. These findings highlight that the process of help-seeking is not always unitary or a direct pathway to treatment. For clinicians, having an effective way to capture and describe pathways to treatment as a dynamic process with choice, coercion, *and* muddling through could prove to be more beneficial for understanding clients and developing personalized conceptualizations to treatment. Additionally, this may serve to inform health researchers and policy makers in understanding the often-complex route to accessing care, which may aid in removing barriers and systematic delays to accessing treatment, supporting the growing numbers of older adults with mental health problems who will need treatment in the coming decades.

*Keywords:* Mental health, help-seeking, older adults, Network Episode Model, service utilization

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## Choice, Coercion, and/or Muddling Through:

## An Exploration of Older Manitobans' Experiences Seeking Psychological Care

According to the Mental Health Commission of Canada, approximately one in five Canadians suffer from mental health problems in any given year (RiskAnalytica, 2011). For those experiencing mental health problems, the rate of treatment-seeking has been shown to decrease as age increases (or to follow a hill-shape, with rates of help-seeking highest in middle age and decreasing from there), with older adults being the least likely age group to receive treatment (Crabb & Hunsley, 2006). This especially low rate of treatment-seeking in the geriatric population is worrisome, as older adults are the most likely age group to present with complicated mental health cases and comorbid physical health concerns, despite effective treatments being available (Beatie, 2016; Byers, Arean, & Yaffe, 2012; Mackenzie, Reynolds, Cairney, Streiner, & Sareen, 2012; Wuthrich, & Frei, 2015). Although much research has been devoted to help-seeking behaviors and service utilization models, the reasons why many older adults with mental health problems do not seek professional help are not fully understood. With a range of complicated and dynamic factors involved (including social networks that involve individuals such as family members and friends, treatment networks that include medical or non-medical service providers, the culture and society of the individual), it is possible that the totality of the help-seeking experience has not yet been considered in those who successfully access treatment. Rather than focusing on a specific aspect of the treatment-seeking journey, an exploration of an individual's multi-faceted journey is important to support those in need of mental health services. This study aimed to capture the dynamic process of older Manitobans' help-seeking pathways, in order to better understand the various pathways that lead clients from their initial concerns about their mental health, all the way through to the clinical psychologists office, and to offer clinicians and policy makers evidence to make informed decisions about best practices for client well-being.

**Older Adults' Mental Health**

With the population aging and living longer, increased pressure is being placed on the already overstretched health care system (Jeste et al., 1999; Prévaille et al., 2009; Reynolds, 2016). It is expected that by 2036 almost one-quarter of the Canadian population- approximately 9.8 million people- will be over 65 (Statistics Canada, 2006), and even with older adults experiencing fewer mental health problems than their younger counter-parts (e.g., Mackenzie et al., 2012; Mosier et al., 2009; Reynolds, Pietrzak, El- Gabalawy, Mackenzie, & Sareen, 2015; Streiner, Cairney, & Veldhuizen, 2006), this still results in a significant number of individuals impacted and needing to access mental health services. Two of the more common mental health disorders in the older adult population are anxiety and depression (Wuthrich & Frei, 2015). According to the 2002 Canadian Community Health Survey-Mental Health and Well-Being (CCHS-1.2), 2.5% of participating older adults met the criteria for at least one anxiety disorder (i.e., agoraphobia, panic disorder, or social disorder) within the past year, while 3.0% met the criteria for past year mood disorders (i.e., major depressive disorder, bipolar I disorder) (Scott, Mackenzie, Chipperfield, & Sareen, 2010). In a similar study utilizing data from the United States National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), Reynolds and colleagues (2015) found past-year anxiety and mood disorder rates (i.e., panic disorder with and without agoraphobia, social phobia, specific phobia, generalized anxiety disorder, PTSD, major depression, dysthymia, and mania or hypomania) of 11.4% and 6.8% respectively. These prevalence rates are much higher than the CCHS-1.2 study in part because the NESARC included all anxiety disorders, whereas the CCHS-1.2 only included three anxiety disorders. The prevalence of older adults' mental health problems increases when looking at subthreshold symptoms, as well as individuals with comorbid chronic physical conditions. In a study of community-dwelling older adults in Quebec, over 34% of individuals reported at least one distress symptom in the past year, and out of those individuals, 34.7% met the DSM-IV criteria for a mood or anxiety disorder (Prévaille et al., 2009). Another study found older adults with chronic physical conditions to be almost four times more likely



to have major depression within the past year than those without (Fiest, Currie, Williams, & Wang, 2011).

The prevalence rates of past or current mental health problems found in older adult samples may not reveal the true picture of geriatric mental health, as there has been a debate regarding the accuracy of these prevalence rates. Several researchers have suggested that true prevalence rates are underestimated; instead they predict a higher prevalence rate of mental health problems in the older population, one that is closer to that of younger adults (e.g., Beekman, Deeg, Braam, Smit & Van Tilburg, 1997; Lebowitz et al., 1997; Prévaille et al., 2009; Streiner et al., 2006; Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005; Wang, Berglund, Olfson, & Kessler, 2004). Such speculations are grounded in the premise that older adults, in comparison to younger adults, report fewer symptoms (e.g., Gallo, Anthony, & Muthen, 1994; Hocking, Koenig, & Blazer, 1995; Klap, Unroe, & Unützer, 2003; Streiner et al., 2006), have poorer episodic memory and therefore have more difficulty remembering symptoms experienced in the past (Jeste et al., 1999; Streiner et al., 2006), are more susceptible to stigma of mental health problems (Jeste et al., 1999), and are more likely to focus on physical rather than emotional symptoms (e.g., Gallo & Rabins, 1999; Hocking et al., 1995; Mechanic, 2007; O'Connor, Rosewarne, & Bruce, 2001; Streiner et al., 2006). Some researchers argue that the diagnostic criteria and measurement instruments available are not appropriate for use with older adults as they have not been validated for use within this population (e.g., Fuentes & Cox, 1997; Palmer, Jeste, & Sheikh, 1997; Scott et al., 2010), while others draw attention to the fact that older adults are more likely to refuse participation in surveys, or are more likely to be excluded from a study sample (e.g., due to being an inpatient or living in a nursing home, or having cognitive decline or physical limitations) (Hocking et al., 1995; Streiner et al., 2006).

Opposing this view, other researchers suggest that the lower prevalence rates found among older versus younger adults within the epidemiological literature is accurate, and that older adults cope more effectively with daily life and stressors. The Strength and Vulnerability Integration (SAVI)

model suggests that adults develop better emotional regulation skills as they age, giving older adults the ability to overcome adversities and deal with day-to-day stress better than they did when they were younger (Charles, 2010). In times of distress or concern, older adults can recall past experiences to problem-solve effectively, and are better able to develop dynamic methods to overcome problems (Blanchard-Fields, 2009). Unfortunately, adverse events are somewhat universal, and older adults may be exposed to unavoidable, significant stress that can weaken or annul the effect of their improved emotional regulation (Charles & Piazza, 2009). Once weakened, older adults are more vulnerable to physical and psychological issues, placing them at greater risk for distress and mental health problems (Beatie, 2016; Mackenzie et al., in preparation; Mackenzie et al., 2012). This weakening may be exacerbated due to a physiological decline; as individuals age, they tend to experience changes in physical systems, abilities, and functioning (for example, slower physiological arousal and less flexibility), which may result in poorer emotion regulation outcomes (Charles, 2010) and a greater difficulty in recovering from stressors.

SAVI predicts that there are several role and lifestyle changes that may put older adults at risk for the development of mental health problems, including social isolation and caregiving. Being socially isolated and lonely, as a result of having a small or unsupportive social network, and participating infrequently in social activities, has been linked to physical and mental health risks (Cornwell & Waite, 2009). A lack of social connection has been associated with a variety of health concerns, including depression (Heikkinen & Kauppinen, 2004), cognitive decline, and mortality (Barnes et al., 2004; Wilson et al., 2007). Older adults are more prone to social isolation, especially when transitioning through stressful life course transitions, health problems, and disabilities (Brummett et al., 2001). For older adults, the passing of friends and family, as well as role changes (e.g., retirement) and health problems increase the need for social connections to stave off isolation (Cornwell & Waite, 2009).

Many older adults take on the role of caregiving for their spouses, parents, children, family members, friends, or neighbours. Within Canada, 28% of caregiving needs are age-related (Statistics Canada, 2012), and spouses have been found to be most likely to provide care for older adults still living in the community (American Psychological Association, 1997). Although the majority of caregiving tasks are tangible (e.g., providing transportation, making food, doing house maintenance, etc.), almost 90% of caregivers also report offering emotional support (Statistics Canada, 2012). This invisible load can take a toll on caregivers, as the amount of time spent taking care of others can be significant and last for years. Although many caregivers report that they are effectively coping with caregiving tasks, when asked more specifically about their well-being, caregivers report physical and emotional health concerns, irritability, and disturbed sleep (Statistics Canada, 2012). They also disclose feeling overwhelmed, tired, stressed, and worried or anxious (Statistics Canada, 2012). A meta-analysis drawing from 84 articles on the differences between caregivers and non-caregivers found that comparatively, caregivers have lower levels of subjective well-being, and higher levels of stress and depression than non-caregivers (Pinquart & Sörensen, 2003).

Although the improvement in mental health across the lifespan found within epidemiological studies is encouraging, aging researchers have demonstrated potential vulnerabilities to which many older adults are susceptible. SAVI reminds us that older adults, when encountering negative life events, are susceptible to clinically significant mental health problems (Charles, 2010). This is especially true when these significant life events are coupled with social vulnerabilities. Therefore, it is important to understand the help-seeking processes of older adults needing mental health services to better help this unique population when they may need it most.

### **Barriers to Mental Health Service Use**

Despite the fact that mental health problems are serious and common, multiple large-scale studies (e.g., Byers et al., 2012; Prévile et al., 2009) have shown that fewer than 40% of those suffering from mental health problems seek professional services (Vogel, Wade, & Haake, 2006a).

Therefore, it is important to understand what help is being accessed, when, how, and by whom.

Throughout the help-seeking literature, multiple need-specific factors are indicative of a greater likelihood of seeking help. For older adults, the presence of a disorder or diagnosis, higher levels of distress, and higher levels of perceived need are more predictive of service use (Cole, McCusker, Sewitch, Ciampi, & Dyachenko, 2008; El-Gabalawy, Mackenzie, & Sareen, 2015; Mackenzie et al., 2012; Mackenzie, Pagura, & Sareen, 2010; Phillips & Murrell, 1994; Pickard, 2004; Scott et al., 2010; Stefl & Prospero, 1985; Wang et al., 2004).

There are multiple differences between older adults and younger adults in terms of the help-seeking process, including the services utilized and professionals consulted. Younger adults were twice as likely to access mental health professionals as older adults in a study by Robb and colleagues (2003), and service utilization continues to decrease as age increases, with older-old (75+) adults using fewer services than younger-old adults (65-74 year olds) (Cole et al., 2008; Crabb & Hunsley, 2006; Mackenzie et al., 2008). Research by Mackenzie and colleagues (2012) demonstrated that older-old adults sometimes do seek services more frequently than younger-old adults but only when experiencing specific mood or anxiety disorders; within the study, those with generalized anxiety disorder, post-traumatic stress disorder, specific phobias, and major depression sought help more than the slightly younger cohort (Mackenzie et al., 2012). When older adults do access care, it is more frequently from their primary care providers than from a mental health professional (Issakidis & Andrews, 2006; Lippens & Mackenzie, 2011; Mackenzie et al., 2010; Mickus, Colenda, & Hogan, 2000; Robb, Haley, Becker, Polivka, & Chwa, 2003; Prévile et al., 2009). When primary care providers are the first (or only) treatment provider enlisted for mental health problems, symptoms of mood or anxiety disorders, as well as caregiver stress may go undetected (Mackenzie et al., 1999; Park & Unützer, 2011; Reynolds, 2016; Unützer, 2002). It has been suggested that the inability to provide comprehensive and effective mental health treatments for older adults may be due to a lack of geriatric knowledge or training (Bartels & Drake, 2005), or because of the many conflicting demands (e.g., high patient

numbers, limited time with patients, treating other medical problems, managing medications) placed on doctors in primary care clinics (Bartels & Drake, 2005). Research has shown that primary care physicians are more likely to provide unsuitable care for older adults with mental health problems, when compared to older adults without mental health problems (Druss et al., 2001), and younger adults with mental health problems (Bartels, Horn, Sharkey, & Levine, 1997).

Similar to their younger counterparts, older adults are more likely to seek treatment if they perceive lower levels of social support (Phillips & Murrell, 1994; Pickard, 2006; Scott et al., 2010). Older and younger adults have also been found to have a similar level of willingness to access mental health services, although fewer older adults access these services (Segal, Coolidge, Mincic, & O'Riley, 2005). This suggests that other barriers are getting in the way of older adults' access to mental health services.

Barriers to mental health services may also be represented as individual attributes that hinder, pause, or halt access to services. Mental health literacy, which includes an individual's knowledge of how to prevent, manage, and recognize mental disorder symptoms, as well as when and where to access appropriate care for their mental health problems (Jorm, 2012), is related to help-seeking. Lower levels of mental health literacy may delay or prevent people from accessing the care they need, or contribute to them moving around within the health care system (Andrade et al., 2014; Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Fisher & Goldney, 2003; Fossey, Harvey, Mokhtari, & Meadows, 2012; Gulliver, Griffiths, & Christensen, 2010; Gum, Iser, & Petkus, 2010; Hasin & Link, 1988; Highet et al., 2002; Judge, Enstroff, Perkins, & Penn, 2008; Kantor, Knefel, & Lueger-Schuster, 2016; Robb, et al., 2003; Stefl & Prospero, 1985; Wetherell et al., 2009). Robb and colleagues (2003) found that older adults felt less confident and knowledgeable about mental health problems, when to seek professional help, and the treatment options available, in comparison to younger adults. Similarly, in a study investigating mental health literacy, older adults (70+ years of age) were least likely to identify the symptoms of mental disorders when reading a vignette about an individual dealing with

mental health problems, and were more likely to rate informal supports (such as talking to members in their social network) poorly, when compared to younger adults (Farrer et al., 2008). The older sample was also less likely to endorse various professional treatment types as effective (Farrer et al., 2008). Due to lower rates of mental health literacy, older adults may be more likely to misunderstand or misattribute changes in mood and behaviours caused by a mental health problem, to another cause (e.g., physical illness). Such symptom misattribution was found in one study, looking at individuals with recent mental illness diagnoses (Judge et al., 2008). When participants were asked to retrospectively reflect on their thoughts and behaviours prior to receiving the diagnosis, participants attributed personal changes and behaviour changes (such as calling loved ones less frequently) to things like psychosocial events (i.e., stress), cultural factors, and other personal experiences (i.e., physical illness), rather than mental health problems.

How individuals deal with the day-to-day changes and symptoms of their mental health problems may also limit or delay their help-seeking. A narrative study of individuals confronting their psychotic illness identified three main response patterns: withdrawing, avoiding help, or coming to terms with their illness (Judge et al., 2008). When individuals perceive that they do not need help, regardless of their true symptom severity, they are much less likely to access care (Andrade et al., 2014; Mackenzie et al., 2010). In Mackenzie and colleagues study (2010), they found that older adults had the lowest levels of perceived needs across all participant age groups. Individuals may also utilize “containment” strategies to limit the impact their mental health problems have on their lives, which may include suppressing, ignoring, or concealing the signs and symptoms (Pescosolido, 2011). Research investigating how older adults cope with depression, distress or other mental health problems suggests that some older adults feel responsible for taking care of their own problems and not involving others, including members of their close social network (Andrade et al., 2014; Hadas & Midlarsky, 2000; Kantor et al., 2016; Lawrence et al., 2006; Mackenzie et al., 2006; Mackenzie et al., 2010; Mechanic, 2007; Wetherell et al., 2004; Wuthrich & Frei, 2015). A negative view of self, which can

stem from feeling inferior for needing help from others, may also limit help-seeking (Fisher, Nadler, & Whitcher- Alagna, 1982). Interestingly, Wuthrich & Frei (2015) found that older participants delayed help-seeking because they felt their symptoms were not abnormal given their life circumstances (50%), or because of their age, health conditions or mental health history (30%). They also delayed help-seeking because they regarded their symptoms as not severe enough to require professional help (41%) (Wuthrich & Frei, 2015).

Another barrier to treatment-seeking is stigma; where individuals hold the belief that they will be viewed, or thought of, negatively due to a specific ‘socially unacceptable’ characteristic (Blaine, 2000). Three types of stigma have been identified: *Self-stigma*, *public or social stigma*, and *stigma of seeking help*. Self-stigma has been connected in previous studies to individuals wanting to personally handle their problem (Andrade et al., 2014; Hadas & Midlarsky, 2000; Kantor et al., 2016; Lawrence et al., 2006; Mackenzie et al., 2006; Mackenzie et al., 2010; Mechanic, 2007; Wetherell et al., 2004; Wuthrich & Frei, 2015), as individuals believe that their mental illness is socially unacceptable (Vogel et al., 2006a). Public (or social) stigma, is defined by perceptions that others are socially undesirable for possessing a specific trait or characteristic (such as mental health problems) (Vogel et al., 2006a) and may also act as a barrier to accessing care. Individuals who are concerned with, or conscious of public stigma may avoid accessing care (also known as the stigma of seeking help) for fear of seeming flawed in a way that they deem socially unacceptable in others (Andrade et al., 2014; Gulliver et al., 2010; Jeste et al., 1999; Kantor et al., 2016; Mechanic, 2007; Vogel et al., 2006a). This has been found to be a significant barrier, especially in rural areas (Gulliver et al., 2010), likely due to smaller community sizes, and fewer available resources. Another scenario in which public stigma has been documented is surrounding labels of mental health problems. Once a psychiatric label is applied, a culture of stereotypes and negative images about that mental health problem can be thrust upon individuals, either by those around them, or through their own personal feelings towards mental health problems (Rosenfield, 1997). Segal and colleagues (2005) found that older adults can hold strong

prejudicial views of individuals with mental health problems: that those with mental health problems are untrustworthy, shameful, and possessing inadequate social skills. Therefore, such strongly held negative views towards those with mental health problems may contribute to the low number of older adults seeking help for mental health problems.

In contrast to the above findings on stigma, Mackenzie and colleagues found that older adults were less likely to be impacted by stigma compared to younger adults (Mackenzie et al., 2008). In fact, older adults were seen to have positive attitudes towards seeking help (more than 80% of the sample) and recognized the benefits of mental health professionals (more than 70% of the sample). This demonstrates that the positive attitudes older adults possess towards seeking treatment (which, within the study was measured as a combination of participants' willingness and comfort towards seeking treatment, as well as the stigma against seeking treatment) may outweigh the negative attitudes surrounding accessing mental health services (Mackenzie et al., 2008). This has been documented by other studies as well (e.g., Mackenzie et al., 2006; Stefl & Prospero, 1985).

Help-seeking barriers can also be systemic; such as the resources to access treatment or issues within treatment. One common barrier cited is the cost of treatment, even in countries that offer health insurance and support for mental health services (Andrade et al., 2014; Kantor et al., 2016; Stefl & Prospero, 1985; Wuthrich & Frei, 2015). Limited access to insurance coverage and adequate services was found to be a more of a barrier for older adults, in comparison to younger adults in a US sample (Robb et al., 2003). Transportation was also listed as a significant barrier in multiple studies (Gulliver et al., 2010; Pepin, Segal, Klebe, Coolidge, Krakowiak, & Bartels, 2015; Stefl & Prospero, 1985).

Within the treatment itself, issues with communication, confidentiality and trust with medical and treatment providers can also act as a barrier, including patients feeling that their needs are not being met, that they have not received enough information, or that the provider is withholding important information from them (Fossey et al., 2012; Kantor et al., 2016). These concerns can impact a client's willingness to continue treatment, and also prevent individuals from seeking treatment,



especially if they have experienced or heard about poor relationships with treatment providers in the past. Other barriers relating to treatment involve a lack of referrals to mental health specialists (e.g., psychology, psychiatry) provided by general practitioners, and a lack of unity and consultation between medical and mental health specialists (Cairney, Corna, & Streiner, 2010; Jeste et al., 1999; Mackenzie et al., 2006; Mechanic, 2007; Pepin et al., 2015). Additional barriers within the treatment setting include feeling pressured by short appointment times (specifically in primary care settings), lacking confidence to question the provider, perceiving providers to be ill equipped, feeling as if the provider is not focusing on the desired aspects of treatment, and patients having issues remembering or understanding the information they were given (Fossey et al., 2012; Gulliver et al., 2010).

Although much research has been done in the area of help-seeking barriers, barriers are generally examined separately, or in a piecemeal way. This has prevented a comprehensive and dynamic understanding of how such barriers affect treatment-seeking. To better understand the impact that barriers have on mental health service seeking, it is important to understand the context of traditional service use models, which explore the process of how individuals may seek care.

### **Service Use Models**

In 1951, Parsons developed The Illness Career Model, with the belief that individuals not doing well would want to access medical professionals for their specialized knowledge and expertise (Parsons, 1951). Within this model, after individuals become sick, they recognize something is wrong, evaluate their condition “rationally and scientifically,” (Pescosolido et al., 2013, p. 507), advise those around them of their condition, then either decide to get help (taking on the sick role) or continue on with life as it was before they became ill. Once individuals accept their ‘sick role’, they would reach out to an expert within the medical community, requesting treatment and taking on the patient role. Accepted by the medical professionals, the ‘patients’ would begin the prescribed treatment that similar others had previously received, and once they were healthy again, they would return to their previous ‘normal roles’ and all roles relating to their illness would be abandoned (Parsons, 1951).

Research following Parsons' work aimed to better understand the help-seeking process. Clausen and colleagues (1955) studied men hospitalized with schizophrenia to explore their experiences with accessing treatment. The stories describing the help-seeking processes within their study varied substantially from the ways into treatment suggested by the Illness Career Model (Pescosolido et al., 2013). Unlike the patients that Parsons described, where deviations in normal behavior and functioning would signal the need for medical help, these participants and their families rarely recognized their day-to-day experiences and changes as attributable to a mental illness. Because these symptoms were not 'textbook' mental illness symptoms, but rather a gradual decline in mental health accompanied by confusion and relational strain, help-seeking among participants was not immediate (Pescosolido et al., 2013). The study also found that close others may misconstrue or justify personal changes; public others (such as employers or police) are sometimes better positioned to recognize personal problems as reflecting a change in mental health (Pescosolido et al., 2013, p. 517). Additionally, it was evident that once individuals finally recognized a need for help with their mental health, it was not always a straightforward, voluntary entrance into the system for treatment. It is research such as this which demonstrated that a reflexive and adaptable model, rather than a 'one-size-fits-all' theory may better represent a client's experience coming into, and navigating within, the health care system.

In the following decades, researchers focused on better understanding the complicated journey of seeking care for health problems. In the 1960s, two main models were developed; the Health Belief Model (Rosenstock, 1966, since updated by Henshaw & Freedman-Doan in 2009), and The Behavioral Model of Health Services Use (Aday & Andersen, 1974; updated by Andersen in 1995 and 2008). Rosenstock (1966) focused on an individual's readiness to access health treatment, which stemmed from a combination of feeling susceptible to a particular illness and having a true concern for one's well-being while ill. Additionally, believing a treatment would improve their health status, as well as being psychologically ready to undergo treatment, would together contribute to whether or not individuals would access treatment. The most important feature described within the Health Belief

model was that of a 'cue', or 'being ready' for action- individuals began the treatment-seeking process only after a significant trigger or event. Although this model expands on the understanding of the patient from Parsons' Illness Career Model, it suggests a rather static process to seeking treatment. Instead, examination of the facilitators and barriers to accessing care and exploring clients help-seeking journeys suggests that it would be prudent to view the help-seeking process as more than just individuals meeting a few specific requirements, then directly accessing treatment.

Aday and Andersen's (1974) Behavioral Model of Health Services Use focused on the importance of the family unit, recognizing that individuals do not always make decisions about, or go through, their health care journey in isolation. Rather, whether or not individuals access care is subject to undeniable family factors (i.e., social and economic characteristics) (Andersen, 1995). The model conceived that a combination of three main categories: predisposing characteristics (i.e., demographic, social structure and health beliefs), enabling resources (i.e., personal/family and community), and need (i.e., perceived and evaluated); led to the use of health services (Andersen, 1995). Although the theory suggests that specific combinations of characteristics indicate an increased likelihood to accessing treatment more so than other factor combinations, it does not allow for personal decisions (such as when an individual may choose to access care, or the type of care accessed) to be incorporated into the help-seeking process. Similar to that of the Health Belief Model, this model also represents a static approach to the dynamic movement towards, and away from the treatment system, over time.

Subsequent models developed in the 1980s, 1990s, and 2000s continued to deepen our understanding of the factors contributing to help-seeking. Models such as the 5-Level Filter Model (Goldberg & Huxley, 1980), the Theory of Planned Behavior (Ajzen, 1985), and the Information Processing Model (Vogel, Wester, Larson, & Wade, 2006b) continued to build on Parson's original Illness Career Model. However, these models tended to move from dynamic interactions (between the individual, social groups, and treatment networks) to more static help-seeking processes, similar to that of Rosenstock's (1966) and Andersen's (1995) models. Differing in approach to these static models,

the Network Episode Model (Pescosolido, Gardner, & Lubbell, 1998; Pescosolido et al., 2013) aimed to capture the dynamic and unique pathways individuals may follow to access mental health services. This model considers interactions between the individual, the social network, and treatment network.

### **Network Episode Model and Pathways to Treatment**

Within the mental health treatment-seeking literature, the Network Episode Model II (NEM-II) (Pescosolido et al., 1998; Pescosolido et al., 2013) focuses on the dynamic factors that impact an individual's help-seeking journey (Figure 1). Featuring four main categories of systems (social content or episode base for the individual, the social support network, the illness career, and the treatment system), Pescosolido and colleagues demonstrated the flexibility and multi-relational factors of the systems and features found to contribute to the help-seeking process. While these factors and systems propel individuals towards mental health services, there are multiple pathways that individuals may experience while they attempt to manage mental health problems.

In a study informed by the NEM, Pescosolido and colleagues interviewed participants from the Indianapolis Network Mental Health Study (INMHS) as they accessed mental health services for the first time (Pescosolido et al., 1998). Participants had to meet specific criteria to be included in the study: a significant mental illness diagnosis (e.g., schizophrenia, major depression, or bipolar disorder), with symptoms developing within the past two years. A group of participants with adjustment disorders (diagnosed during the research process) were also included, however they were not compared directly in study analysis. Between 1990 and 1994, 35 males and 74 females ( $N=109$ ), aged 18-72 ( $M= 30.5$ ), participated. Focusing on the 'entry account' to mental health services, participants were asked how they "ended up" in the treatment system (Pescosolido et al., 1998, p. 278). Working definitions of three main types of pathways (choice, coercion and muddling through) were developed, then interviews were each categorized into one of the three pathway types. Upon completion of the study, quantitative analysis revealed 45.9% of participants had a choiceful path to treatment (seeking treatment based on their own decision), 22.9% were coerced (actively resisting seeking help), and

31.2% muddled their way to treatment (neither actively seeking, nor actively resisting treatment).

Rather than sequential steps or an ordered process as outlined in other help-seeking models, the help-seeking process described within the NEM-II is more of a stream, with numerous “patterns and pathways to and from the community and the treatment system” (Pescosolido et al., 2013, p. 517). This model is important in understanding the subtleties and complexities in help-seeking. By framing the help-seeking journeys using the NEM, we capture the intricacies in seeking treatment, that not all individuals enter with a choiceful, rational process, as suggested in the majority of the service use literature. The NEM is one of the only service use models to acknowledge and explain these ‘other’ ways of seeking care. As clients continue on their journey to mental health services, it is important to consider that many people experience multiple mental health challenges throughout their lives, each of which may involve different treatment pathways (Pescosolido, 1996; Pescosolido et al., 2013). A further exploration of the choice, coercion, and muddling through pathway descriptions follows, pulling information from Pescosolido and colleagues’ initial working definition, as well as from other sources throughout the literature.

### **Choice in mental health treatment.**

*Choiceful* pathways to mental health services, according to the Network Episode Model, emphasize clients making a decision to access help, regardless of whether they made that decision solely on their own (*individual choice*), or if clients involved social network members (*supported choice*) for support in the decision-making process (Pescosolido et al., 1998). Although there may be elements of muddling or coercion present while seeking treatment, this type of pathway to treatment emphasizes the client’s agency with respect to the decision to seek care (Pescosolido et al., 1998). Pathways to treatment that feature choice, also seen as a willingness to access treatment, have been found in previous literature to lead to positive treatment outcomes, for example better attitudes towards the treatment provider, better patient-provider relationships, and more positive treatment outcomes (Kaltiala-Heino, Laippala, & Salokangas, 1997; Reynolds, 2016). The concept of choice in relation to

treatment-seeking has been represented in many help-seeking models, where a rational, choiceful decision to enter treatment is required to initiate the treatment-seeking process (e.g., the Information Processing Model (Vogel et al., 2006b), the Health Belief Model (Rosenstock, 1966), and the Behavioral Model of Health Services Use (Aday & Andersen, 1974).

As found throughout the literature, older adults are more likely to access treatment through their primary care provider (e.g., Issakidis & Andrews, 2006; Lippens & Mackenzie, 2011; Mackenzie et al., 2010; Mickus, Colenda, & Hogan, 2000; Robb et al., 2003; Prévaille et al., 2009). Despite older adults' comfort with their primary care physician (generally a stable member of their health treatment system), they may adopt a more passive and less-rational approach to treatment-seeking in the presence of their doctor, especially if they view them as an authoritative figure (Chiu, Feuz, McMahon, Miao, & Sudore, 2016; Reynolds, 2016), a view older patients have been found to hold more frequently than younger patients (Wrede-Sach et al., 2013). Therefore, although patients may enter the doctor's office willingly (choice-fully) to seek out mental health services, they may leave this stop within the health system less self-directed (i.e., muddling through) in the next part of the help-seeking pathway.

### **Muddling through in mental health treatment.**

*Muddling through* pathways, as defined by the Network Episode Model involve 'drifting around' and 'bouncing off' of opportunities and situations to move towards a solution to their mental health problem (Pescosolido et al., 1998). In these instances, individuals do not actively seek or resist a treatment option, but rather enter treatment either by happenstance or through the direction of one or more members from their social network (Pescosolido, 2011). In some cases, individuals may be unsure of how they made it to their mental health services at all, reflecting a bystander's interpretation of the decision-making process (Pescosolido et al., 1998).

Muddling through appears to be quite a consistent aspect in the help-seeking journey, with most individuals in the original NEM study expressing some degree of neither actively seeking out nor resisting care (Pescosolido et al., 1998). This was especially prevalent in cases involving individuals

who had attempted suicide: clients expressed ambivalence between life and death (Pescosolido et al., 1998). In one case, after a participant had taken a bottle of pills, he expressed both wanting to be saved, but also wanting to die, (Pescosolido et al., 1998). Muddling through may also involve members of the social network ‘taking over’ the help-seeking process (Pescosolido et al., 1998). In the case of the individual who had attempted suicide, this was seen when his mother called for the ambulance and he was “put in the car” (Pescosolido et al., 1998, p. 282).

Reynolds (2016) interviewed older adults who accessed mental health services through a clinical psychologist, to better understand their treatment-seeking experiences and previous mental health knowledge. Through these interviews, she identified many instances of muddling through; although each story was unique, participants conveyed similar experiences of the emotionally and physically draining process that brought them to psychological treatment, described by one participant as “limping” through the process (Reynolds, 2016). This ‘limping’ was especially notable when participants lacked direction as they moved from one siloed service in the health care system to the next. As identified by Reynolds, the health care system has been recognized as promoting passivity within patients, especially when diagnoses and referrals are handed down from doctors to patients in a paternalistic manner (Reynolds, 2016).

Additionally, there are multiple features of the help-seeking process that may provide evidence for the classification of a muddling through pathway for older adults. As discussed previously, older adults have reported feeling less comfortable and capable making mental health decisions in comparison to younger adults (Robb et al, 2013). Many researchers have demonstrated that older adults are more likely to have lower levels of mental health literacy (Andrade et al., 2014; Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Fisher & Goldney, 2003; Fossey, Harvey, Mokhtari, & Meadows, 2012; Gulliver, Griffiths, & Christensen, 2010; Gum, Iser, & Petkus, 2010; Hasin & Link, 1988; Highet et al., 2002; Judge, Enstroff, Perkins, & Penn, 2008; Kantor, Knepfel, & Lueger-Schuster, 2016; Robb et al., 2003; Stefl & Prospero, 1985; Wetherell et al., 2009) which may impact if and how

they interpret changes in their mental health. If for instance, a significant, lasting change in mood is not recognized as a potential mental health problem, or is downplayed based on the perceived severity of the symptom (e.g., older adults thinking their mental health problems are relatively normal, or not that severe) or because they are interested in taking care of their mental health themselves, older adults may be more likely to delay help-seeking or make first contact through the general health care system or non-specific alternative such as a community organization for older adults. By having a lower level of mental health literacy, older adults may not know how to seek out and access treatment specific to their needs. This, in addition to the higher levels of complex comorbidity of older adults presenting with physical and mental health problems, may lead to muddling through the health system without a clear direction.

#### **Coercion in mental health treatment.**

Coercion, as defined within the Network Episode Model represents an active resistance or refusal to seek treatment (Pescosolido et al., 1998). Without an external source, individuals who are coerced into care, would not have accessed mental health services at all. Coercion has been broken down further into more specific forms: *hard coercion*, which involves pressure or force by family members, judges, lawyers, or police; and *soft coercion*, which involves more subtle pressure to seek help by family or other social network members (Pescosolido et al., 1998).

Coercion for individuals needing mental health services has been examined, primarily by legal and psychiatry scholars, in studies using convicts and inpatients as participants. Throughout this literature, a clear definition of coercion is lacking (Hiday, 1992; Lidz & Hoge, 1993; Monahan et al., 1995). According to Hiday (1992), “coerced choice” involves clients feeling forced or otherwise made to make a choice they would not have made on their own. Coercion represents a lack of autonomy for the patient (Bindman, 2004), where being lied to, left out of the decision-making process, treated with a lack of respect, and/or being manipulated by individuals with ulterior motives can create feelings of



coercion (Lidz, 1998). Additionally, harder coercive tactics may include being physically controlled or brought to the hospital by the police (Monahan et al., 1995).

Social network members play a key role in coercion, even in the ‘softer’ forms. The MacArthur Perceived Coercion Scale (MPCS) (Gardner et al., 1993) has been used in research to explore the sources of influence individuals may encounter, and involves four types of influence and pressure that may impact decisions to access care: *persuasion* (e.g., trying to talk the patient into treatment), *inducement* (e.g., offering or promising the patient something), *threats* (e.g., threatening the patient), and *force* (e.g., forcing the patient) (Hoge et al. 1997). Leverage, another higher level of pressure, occurs when a clinician or family member expresses disapproval or withdraws emotional support from the patient if their wishes are not being met (Bindman, 2004). Within a study of 157 hospitalized patients, persuasion was the most common form of coercion, for both voluntary and involuntary patients (Hoge et al., 1997). In an inpatient study by Monahan et al., (1995), interviews with the family members and hospital staff of the patients suggested that more pressure was being placed on patients upon entry to the hospital than the patients recalled. Monahan and colleagues suggested that once patients were allowed to participate in the treatment planning process, they may reflect differently on their original treatment entry. This study provides evidence that individuals may change their feelings and perceptions of the help-seeking process when recalling it later, especially if their role in the process changes.

Reflecting the influence of ‘others’ involvement in accessing treatment, Hoge and colleagues (1997) found different accompaniment patterns upon hospital admission for voluntary and involuntary patients. A large number of patients entering treatment voluntarily were accompanied (55.6%), most often by relatives (31.1%), whereas the majority of involuntary patients were accompanied (81.7%), most often by custodians (51.7% with custodians including therapists, police, and ambulance). Different types of accompaniment may suggest different types of coercion; comparing these findings to that of the NEM-II pathway model, unaccompanied voluntary individuals may represent clients who

exercised individual choice in entering treatment, while accompanied involuntary clients may represent both soft (e.g., family accompaniment) and hard forms (e.g., custodian) of coercion, depending on the individual(s) accompanying the client. Although coercion occurs in outpatient and community mental health clinics, very little research has been directed in these areas to understand true prevalence rates and the impact that pressure and force have on clients to attend, and stay in treatment (Molodynski, Rugkåsa, & Burns, 2010).

### **Choice, coercion and/or muddling through.**

In their original 1998 paper, Pescosolido and colleagues coded each pathway to treatment as representing an instance of choice, coercion, or muddling through. But what about the clients that have a complex pathway to care? Currently, there is no clear indication of how to appropriately classify individuals if their treatment experience fits into more than one pathway, which could lead to an inaccurate or simplistic description of their experience.

As noted within the NEM-II (Pescosolido et al., 1998), clients experience unique, dynamic, and continually-evolving help-seeking process as they make their way further into, and out of, the treatment system. Because of the unique quality to the treatment-seeking experience, it is realistic to anticipate that each client's experience will not fit cleanly into one pathway. This was the case within the work introducing the Network Episode Model, in which Pescosolido and colleagues featured an excerpt from a participant, which "rests on the borderline" (Pescosolido et al., 1998, p. 280) between two pathways, *individual choice or supported choice*. Although the authors provided justification for the final allocation, that "the latter is more consistent with the Network-Episode Model which sees even rational choices as embedded within a social network process," (Pescosolido et al., 1998, p. 280), they did not provide any methods for rectifying other 'borderline' cases that may arise. It was noted that across participants, there was movement through the different pathways (i.e., from muddling to choice). However, in the end, each participant was given one category to describe their entire treatment-seeking journey; there was no description provided, or allowance for, any overlap between the pathways.

Muddling through was also highlighted as somewhat of a constant in the help-seeking process: “in the end, many, if not most, of the accounts had some component of muddling,” (Pescosolido et al., 1998; 281). Beatie (2016) echoed similar difficulties in trying to classify participants’ pathways, although this wasn’t the primary aim of her study. These examples demonstrate that the classification of pathways is complex, and at this point, open to interpretation.

Within the help-seeking journey, some clients may have a straight-forward help-seeking pathway, fitting clearly within choice, coercion, or muddling through. Others may experience multiple pathways at various points in their treatment-seeking journeys. I argue that by requiring a classification of only one pathway to describe the complete help-seeking experience (for example, classifying a pathway as choiceful even though clients may have muddled through for years and only expressed choice at one point in the help-seeking journey), important information is being left out. Throughout the help-seeking journey, it is likely that some individuals will experience a change. I argue that those changes (or lack of changes) are just as valuable as understanding the ‘overall pathway to treatment’ a client travels on, especially if a clinician is using such classifications in client conceptualizations. It is therefore important to consider whether classifying clients into one of three pathways represents *enough* of their overall journey to treatment. One suggestion discussed by Beatie (2016) was to look at the pathways as “choice, coercion, *and* muddling through” as opposed to “choice, coercion, *or* muddling through” (Beatie, 2016, p. 58). Therefore, I planned to examine help-seeking journeys and categorize them into a specific pathway, as was done by Pescosolido and colleagues (1998), but additionally explore each interview to determine the extent that each of the three pathways (choice, coercion and muddling through) was featured. This way, the variation within each participant’s help-seeking journey can be examined, and any patterns emerging across participants can also be considered and included.

The development of the choice, coercion, and muddling through pathways in conjunction with the NEM provided a base from which to identify the varying ways individuals come to access mental

health services. Although seen as effective, the development of these pathway classifications was based on pre-determined working definitions and supported with data from one sample. As older adults have unique needs and experiences when navigating the help-seeking process (Reynolds, 2016; Beatie, 2016), it is important to explore the choice, coercion, and muddling through pathways within an older Canadian population, to determine how this may differ from Pescosolido and colleagues' original middle-aged American sample. There are three main reasons to explore whether the three pathways identified by Pescosolido and colleagues can be replicated within an older Canadian outpatient population. First, Pescosolido and colleagues interviewed younger Americans with one of three serious mental health problems (schizophrenia or other psychotic disorder, major depression, or bipolar disorder) or identified for the comparison group with a research diagnosis of adjustment disorder. The sample in the present study consisted of older Manitobans with a broader range of mental health problems (such as caregiver stress, anxiety, depression, complicated grief, daily stress). Second, the health care systems within the United States of America in the 1990s (Pescosolido's study) are different than that of the current Canadian health care system. Differences in health care systems (e.g., private funding of treatment in the U.S. vs access to publically-funded treatment in Canada) may lead to differences in help-seeking pathways. Finally, Pescosolido and colleagues developed their three pathways based on a brief content analysis as part of a larger, mixed-methods study. For the proposed study, the focus of interviews were primarily to understand how older adults came to access mental health services at a clinical psychology clinic. The analysis to follow will be in-depth and purposeful in identifying and examining these three specific pathways within participants' interviews.

### **Research Objective**

Currently, no research has been conducted with a focus on classifying the help-seeking experiences of older Canadians into the three pathways identified by Pescosolido and colleagues (1998). This research will address this gap in the literature, while also attempting to explore whether the pathways should represent distinct treatment journeys, or if they are best conceptualized as co-

occurring processes within one's help-seeking journey. Further, understanding how individuals access mental health care is important in planning for and evaluating the current mental health system. Additionally, in understanding clients pathways to care, clinicians may find this to support and enhance their case conceptualization and treatment planning. As such, there are two main objectives of this study: 1) classifying the older Manitoban participants help-seeking pathways, using the Network Episode Model (Pescosolido et al., 1998), and 2) exploring whether the pathways should represent distinct treatment journeys (i.e., choice, coercion, *or* muddling through), or if they are best conceptualized as co-occurring processes (i.e., choice, coercion, *and* muddling through).

## Method

### Research Strategy

Qualitative methods have been employed within the health sciences to gain a better understanding of patients' individual experiences, with the recognition that health, illness, and treatments are all subjective (Thorne, 2011). Researchers learn from individuals who have navigated through the help-seeking journey because, despite having the "best-planned services" available, each interaction with service and treatment providers contributes to a unique delivery of health services (Thorne, 2011). An in-depth understanding of the patient's experience is something that can be explored through qualitative research in a way that cannot be captured through quantitative measures (Smith & Firth, 2011).

For this study, I utilized secondary data, specifically, data that was previously collected by three other researchers for their unique studies, to answer a new research question. Although employing secondary data is generally an under-utilized method in qualitative research, more attention has been paid to this method of data collection in recent decades (Lewis & McNaughton Nicholls, 2014). Within qualitative research, there may be hesitancy to use utilizing secondary data due to the missing knowledge that is normally acquired during the data collection and initial analysis (Heaton, 2004). By

not being with the participants during data collection, and not being able to commence data analysis during the interview process to inform the remaining data collection, I was unable to focus the participants in a way to best answer my research question and ensure saturation (Heaton, 2004). I was also unable to change interview protocols throughout the research process as is typically done after the initial participants are interviewed. Another reason qualitative researchers may be slower to adopt the use of secondary data is due to concerns with confidentiality, which is much easier to ensure when numerical data is passed between researchers (Heaton, 2004). Within this study, no identifying information was passed on from the original data, as de-identified pseudo names were used within the transcripts. Additional details, such as doctors or clinic names, were removed. In contrast to these drawbacks to using secondary qualitative data, a major benefit is the ability to utilize a larger sample size (Ritchie, Lewis, Elam, Tennant, & Rahim, 2014), as issues with recruitment of this population (Hocking et al., 1995; Streiner et al., 2006) may otherwise have limited the number of participants that could be included within the Master's thesis timeframe. By using a larger sample, it is more likely that the research question will be answered (Malterud, Siersma, & Guassora, 2016), because we have a larger group of participants sharing their unique experiences. Additionally, the larger sample will be a better representation of the population being studied. Research has also shown that it is useful to have a larger sample when attempting to extend existing knowledge and theory (Malterud et al., 2016). At the same time, using secondary data means that certain analysis methods, such as grounded theory, are not suitable, due to the following reasons: first, because the recruitment and data collection phases were completed by the original collaborating researchers prior to the initiation of this project (Beatie, 2016; Reynolds, 2016), second, analysis cannot occur concurrently to ensure data saturation. Third, saturation may not be met- in the case of Mackenzie et al., (ongoing), only five interviews are being completed at each clinic, regardless of the nature of the data collected from each clinic.

To examine help-seeking pathways in a sample of older Manitobans with mental health problems accessing a clinical psychologist (or clinical psychology trainee), I compiled de-identified

qualitative interviews and associated data from three independent but related studies: Beatie (2018), Reynolds (2016), and Mackenzie et al., (ongoing). These three studies explored the process of seeking psychological treatment for mental health problems, but did so with different research objectives, participants, and interview protocols. Although all studies examined participants' pathways to care, Beatie (2016) and Reynolds (2016) did not explicitly focus on Pescosolido's (1998) choice, coercion, and muddling through pathways, and Mackenzie et al., (ongoing) is focusing on the impact of social influences on accessing treatment across the adult lifespan, with only a small portion of the sample consisting of older adults. These studies have also taken place at different times; Reynolds (2016) conducted interviews between October 2013 and July 2014, Beatie (2016) conducted interviews between August 2015 and March 2016, and Mackenzie et al., (ongoing) study began at the end of July 2017, and interviews commenced in August 2017.

### **Data Collection Procedure & Instruments**

As the studies were conducted independently, three different data collection procedures were utilized. Although the procedures were similar, the data collected in each study differs slightly. For all three studies, ethical approval was received from the University of Manitoba, St. Boniface Hospital, and/or Health Sciences Centre prior to participant recruitment. The majority of participants were recruited from the St. Boniface Hospital Geriatric Psychology Outpatient Clinic in Winnipeg; two participants were recruited as a part of Mackenzie and colleagues' study through the Health Psychology Clinic at the Health Sciences Centre in Winnipeg, and the Psychological Service Center at the University of Manitoba. To meet inclusion criteria, participants had to be at least 60 years old (with the exception of Mackenzie et al., ongoing, where participant age had to exceed 18), speak and comprehend English, and be attending the clinic they were recruited from for outpatient psychological treatment at time of recruitment. Individuals with suspected cognitive impairment were not considered eligible for the study. Collaborating clinical psychologists, and their trainees (graduate student practicum students or residents) identified clients they believed met the inclusion criteria, and provided

them with basic information about the study. If these clients were interested in participating or learning more about the study, they completed a ‘consent to be contacted form.’ This form provided a summary of the study, and by signing it, these potential participants consented to being contacted by researchers associated with each study by email or phone. Once potential participants completed the form, the collaborating clinical psychologists informed the primary investigator or research assistant, and the form was picked up from the clinic office. Clients were contacted by the primary investigator or research assistant to discuss the study in further detail and schedule an interview time and location. Interviews were primarily conducted within participants’ homes, to address potential transportation and physical barriers. Participants were also given the option to conduct the interview at their therapy clinic, or in the Aging and Mental Health Laboratory at the Fort Garry Campus at the University of Manitoba.

At the beginning of each interview, the consent form was reviewed by the principal investigator or research assistant, and questions were answered prior to the participants providing their consent to continue with the study. Participants signed and were provided with a copy of the consent form, given their honorarium, and asked to complete pre-interview questionnaires (Beatie, 2016; Mackenzie et al., ongoing; Reynolds, 2016) and mental health across the lifespan graphs (Beatie, 2016; Mackenzie et al., ongoing). An audio recorded, semi-structured interview then took place, lasting approximately one-hour in length (with times ranging from about 30 minutes to 120 minutes). Following the interview, participants were provided with debriefing information and a listing of community mental health resources. A compilation of participant information utilized for the study is included in table 1.



Table 1  
*Compilation of Sample Characteristics*

Characteristics	Participants ( $n = 35$ )
Mean ( <i>SD</i> ) age, range: years	71.5 (7.05), 61-87
Male (%)	10 (28.6)
Female (%)	25 (71.4)
Race/ethnicity (%)	
White	33 (94.3)
Indigenous	1 (2.9)
Filipino/Malaysian/Indonesian	1 (2.9)
Marital Status (%)	
Married or Common Law	23 (65.7)
Single	1 (2.9)
Divorced/Separated	4 (11.4)
Widowed	7 (20)
Employment Status (%)	
Full-Time Employed	1 (2.9)
Part-Time Employed	3 (8.6)
Retired	29 (82.9)
Unemployed / On Disability	2 (5.7)
Mental Health Diagnosis (%)	
Received a diagnosis	19 (54.3)
Never received diagnosis	16 (45.7)
Diagnoses (%)	( $n = 19$ )
Anxiety Disorders	3 (8.6)
Mood Disorders	10 (28.6)
Anxiety & Mood Disorders	3 (8.6)
Trauma & Stressor-Related Disorders	3 (8.6)
Reason for Seeking treatment	
Anxiety Disorders	14 (40)
Mood Disorders	10 (28.6)
Trauma & Stressor-Related Disorders	1 (2.9)
Coping	2 (5.7)
Stress	1 (2.9)
History of stressful life experiences & trauma	3 (8.6)
History of addiction	1 (2.9)
Grief, fear of being alone	2 (5.7)
Caregiver stress	10 (28.6)
Coping with health issues/diagnoses (e.g., diabetes, Parkinson's)	6 (17.1)
Familial Stress	3 (8.6)

*Note.* Many participants ( $n = 13$ ) described unique pairings of the above reasons for seeking treatment. Rather than listing each individual's combination of symptoms, each symptom described by an individual was included.

To better understand the unique aspects of the three original studies, a description of each study will follow, first with an introduction describing the study, followed by a description of the methods utilized.

**Study 1: Reynolds (2016).** With previous literature findings suggesting that older adults have a desire to be involved with decision-making regarding their health care, despite the low prevalence rates of seeking mental health treatment, Reynolds sought to explore the pathways to seeking information and treatment. Reynolds' (2016) doctoral dissertation included a qualitative study exploring older adults' help-seeking pathways, with the objective to elicit their personal narratives, and subsequent meaning-making, of their journeys accessing mental health treatment.

**Methods.** Reynolds (2016) collected three types of data during the interview process: A demographic questionnaire, a semi-structured in-depth interview, and field notes. The demographic questionnaire (see Appendix A) focused on basic personal information, including age, gender, marital status, occupational status, household income and race/ethnicity. The interview protocol (Appendix B) focused on the participants' mental health concerns, the evolution of the concern, and the personal, familial, and systemic factors that impacted seeking help. Participants were also asked about their previous mental health treatment history, and what they knew about therapy before they came into the clinic for help. Interviews ranged from 60 to 120 minutes in length. Detailed, observational field notes were completed by Reynolds following the interview. Using narrative analysis (Riessman, 2008), Reynolds examined how older adults described and used language to make meaning of seeking psychological treatment for mental health problems. Participants consisted of 15 older adults (11 female and four male). These participants ranged in age from 61 to 86 years old ( $M = 71.6$ ,  $SD = 7.4$ ), with the majority of individuals being White (93.3%), retired (86.7%), and married (53.3%).

**Study 2: Beatie (2016).** This study was designed to explore older adults' discussions of their journeys accessing psychological care, specifically, the dynamic interactions that occur within

participants' mental health problem and various contexts, including their interactions with social and treatment networks, suggested within the Network Episode Model-II (Pescosolido et al., 1998).

**Methods.** Beatie (2016) collected four types of data: background and health questionnaires, mental health across the lifespan graphs, in-depth qualitative interviews, and field notes. Within the background questionnaires, participants answered sociodemographic questions and provided information about their health, social isolation and connectedness (using the Lubben Social Network Scale, LSNS-6; Lubben et al., 2006), and level of distress (Kessler Psychological Distress Scale-6, K6; Kessler et al., 2003) (Appendix C). The mental health across the lifespan graph was used to capture the fluctuations of mental health throughout the participant's life (Appendix C) and was used within the interview to initiate discussion on mental health history.

The interview protocol (see Appendix D) focused on the participants' current mental health concerns, help-seeking pathways, and the social and cultural influences that impacted the individuals' treatment-seeking processes. Questions also focused on the participants' thoughts about the treatment they were receiving, their mental health and treatment history, and the impact that social, cultural, and organizational factors had had on that history. Interviews ranged from 40 to 90 minutes in length. Field notes were completed by Beatie in private after concluding the interview; these focused on the participants' homes and body language throughout the interview. With a framework analytic approach (Pope, Ziebland & Mays, 2000; Ritchie & Spencer, 2002) transcripts were analyzed to identify the NEM-II major themes and sub-themes that helped or delayed help-seeking. Participants consisted of 15 older adults (10 female and five male). These participants ranged in age from 63 to 87 years old ( $M = 72.3$ ,  $SD = 6.6$ ), with the majority of individuals being White (93.3%), retired (86.7%), and married or common-law (86.7%). 53.3% of the participants reported being diagnosed with a mental health problem; 57.1% of participants had been diagnosed with anxiety, while 42.9% had been diagnosed with depression (Beatie, 2016).

**Study 3: Mackenzie et al., (ongoing).** This qualitative study was designed to explore help-seeking, highlighting the psychosocial and structural components as featured within Pescosolido's (1991) Network Episode Model, with participants collected from seven outpatient health and mental health clinics in Winnipeg. As a member of the research team (comprised of Drs. Corey Mackenzie, Kristin Reynolds, Renée El-Gabalawy, Patricia Furer, Pamela Holens, Lesley Koven, Donald Stewart, Harold Wallbridge, as well as graduate students Aleah Fontaine and myself) since the onset of study, I have been conducting interviews with participants, including all but one of the interviews being used for the current study. Data collection began in the fall of 2016, and at this time 32 out of 35 interviews have been conducted. Recruitment opened for the St. Boniface Geriatric Psychology Clinic in July 2017, currently, three interviews have been completed. Two participants from other clinics (Health Psychology Clinic and the Psychological Services Centre) were also included in the current study, to provide additional participants that may possess different diagnoses and different experiences accessing care as they did through two other clinics. Within the interview, participants are asked about their most recent pathway to mental health services, as well as their previous experiences with mental health problems. If treatment was sought in the past, this was also discussed.

**Methods.** Mackenzie et al., (ongoing) utilized four main forms of data collection: background and mental health questionnaires, mental health across the lifespan graphs, in-depth qualitative interviews, and field notes. The background questionnaire (see Appendix E) includes demographic questions, diagnosis and treatment information, and a listing of previous mental health services. Participants were also asked about their physical health, the influencing factors (people and institutions) that led to seeking treatment, and their help-seeking pathways. One question explicitly focused on the three help-seeking pathways from the NEM-II (Pescosolido et al., 1998), asking participants to indicate how much they 'chose,' were 'pressured or coerced,' 'bounced around,' or 'led' into the treatment they are receiving. The semi-structured interviews focus on the participants' current mental health problems, their previous knowledge of mental health and mental health services, how

they accessed mental health services, and the social and institutional factors that were involved with them accessing care. Participants explained what they drew on their mental health graph in detail, and were asked to discuss previous instances of help-seeking, and the individuals or other influences that may have played a role in them accessing care. Interviews ranged from 35 to 65 minutes in length. Finally, interviewers completed field notes in private upon completion of the interview, which highlighted the participant's appearance and body language, as well as differences noticed throughout the interview. Within the original study, interview data was analyzed using a constructivist grounded theory approach (Charmaz, 2014). Participants from Mackenzie et al., (ongoing) included five participants from across three clinics (three participants from St. Boniface Geriatric, as well as two participants from other clinics that meet the criteria of being over 60 years of age). Participants consisted of four females and one male, ranging in age from 62 to 82, ( $M = 69$ ,  $SD = 8.2$ ). All individuals were White (100%), and the majority of participants were retired (60%), and married (60%). 80% of the participants received diagnoses for their mental health concerns, which included adjustment disorder (20%), PTSD (20%), Depression (20%) and PTSD and complicated grief (20%).

### **Analysis**

I began analysis for the current study after receiving ethical approval from the Psychology/Sociology Research Ethics Board (PSREB) to combine and re-analyze the data. Then, I compiled the transcripts and additional data collection materials (demographic, health information, and field notes) for analysis. Because the analysis for this study is independent to that of the original three studies, no original analysis information was provided or referenced for the purpose of this study.

To start, all data was uploaded into the qualitative data organization program NVivo 10. NVivo 10 has been developed to organize and compile all types of qualitative data (audio, transcripts, field notes, analysis notes, etc.) and provide a centralized location for coding and thematic review. Due to the large amount of data used for this study, the use of computer software increased organization and ensured accurate coding, while also providing a reliable audit trail using date and time stamps.

Throughout analysis, I remained focused on the expressed help-seeking journey of the participants, namely the way they described their interactions with various care providers and members of their support networks as they moved through the help-seeking journey. The primary foundation of the initial framework were based on definitions of choice, coercion, and muddling through by Pescosolido and colleagues' (1998), and supported through the participants' own language and experiences. Choiceful pathways reflected participants' active role in seeking care. Stories of choice included details of wanting to get help, or recognizing a need within the self to do so; mental health help was something that was sought out independently (individual choice), or with support from their social network (supported choice). When support was provided by social network members, I ensured that the events preceding treatment were still primarily driven by the willing participant. In contrast, participants with a coercive pathway discussed active resistance to accessing care. This may be represented subtly, such as feeling pressure from a loved one, or more strongly and explicitly, where participants were forced to seek treatment against their will. Somewhere in between choice and coercion falls muddling through; participants were neither actively seeking, nor actively resisting treatment. Muddling through may be represented as a 'lack of direction' or 'bouncing around' within the process of accessing treatment, or by an outside individual taking the lead of the help-seeking process.

With an explicit focus on the three types of pathways from the NEM-II (Pescosolido et al., 1998), the use of secondary data for this study allowed me to further explore the participants' help-seeking pathways with an objective that differed from each of the original studies. When selecting a data analysis method, I considered the following points: the analysis method would need to be suitable for analysis commencing after all data had been collected. The method would also need to allow for the combination of multiple studies with different protocols and research objectives to form one final analysis identifying common themes (Ward, Furber, Tierney & Swallow, 2013). In order to meet these requirements, I considered framework analysis (FA) (Ritchie & Spencer, 2002), interpretive description

analysis (Thorne, 2011), and content analysis. Although interpretive descriptive analysis allows for a logical structure, it requires purposeful sampling and concurrent data collection and analysis (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004; Thorne, 2011), two things which are not possible in this secondary data study. I also considered Framework analysis (Ritchie & Spence, 2002) because it is designed to investigate a specific set of aims and objectives; it provides an emphasis on how a priori theories and emergent data should be integrated to develop a framework (Parkinson et al., 2016); it is compatible with NVivo qualitative software (Parkinson et al., 2016); and finally, because of its structured approach, which would be helpful with the larger body of data being used in this study. Finally, I considered content analysis for many of the same reasons as framework analysis (specific aims, compatible with NVivo, and structured approach), with the following additional benefits: first, there are three unique types of content analysis (conventional, directed, and summative, Hsieh & Shannon, 2005), which allows for coding to be completed once, with different analytic goals being met; and second, the ability to explore the characteristics of language to distinguish content and contextual meaning (Hsieh & Shannon, 2005). In order to achieve both study objectives with the same method, I decided to analyze the data using two different content analysis methods.

**Content analysis.** Content analysis has a long history, with initial use dating back to the 18<sup>th</sup> Century (Rosengreen, 1981). Today, researchers are most likely to associate content analysis with a quantitative type of qualitative research: a specified research unit (e.g., word, sentence, participant, etc.) is coded into unique categories, and all categories are counted and described using quantitative statistics (Hsieh & Shannon, 2005). Although this method, which is sometimes referred to as the 'quantitative analysis of qualitative data' (Morgan, 1993), is often used to quantify qualitative data, it can also be used to delve more deeply into the data. Within this study, content analysis was used to explore the language of the participants, classifying each aspect of participants' help-seeking journey into one of the pre-determined categories. By using content analysis as a systematic classification system, themes were explored in an efficient manner: each participant's experience was grouped with

similar experiences of others, to look for patterns, seek out differences, and develop a more thorough understanding of the help-seeking journey these participants have experienced. Using content analysis allowed me to keep the data and eventual findings close to what the participants have said, highlighting instances to support whether, and to what extent, the choice, coercion, and muddling through pathways were present in the older adult sample. To meet my two objectives, I utilized two different types of content analysis: for objective one (classifying the older Manitoban participants help-seeking pathways), I utilized directed content analysis, and for objective two (exploring whether the pathways should represent distinct treatment journeys (i.e., choice, coercion, *or* muddling through), or if they are best conceptualized as co-occurring processes (i.e., choice, coercion, *and* muddling through), I utilized conventional content analysis.

To explore my first objective, replicating Pescosolido's (1998) study classification of choice, coercion, and muddling through with an older adult sample, I used directed content analysis, which is recommended for use when the study objective is to further understand and validate existing theory and prior research (in this case, the type of pathway to treatment; Hsieh & Shannon, 2005). This includes three main stages, including (1) developing categories of interest or codes, (2) creating operational definitions for the codes, and (3) coding transcripts using codes. To begin, I consulted Pescosolido's original work and extracted all content describing the three pathways (choice, coercion, and muddling through). I then used these descriptions to clarify the three main categories, with two sub-categories within each category, to serve as a basis for classifying participants into one type of pathway or another (Figure 2).



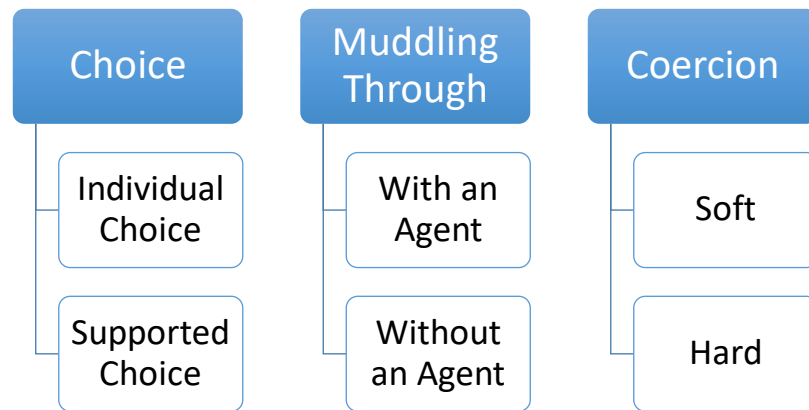


Figure 2. Primary Themes and Sub-Themes.

Next, I created the operational definitions for each theme and sub-theme for coding transcripts, which were taken from Pescosolido's descriptions (1998) of the pathways and sub-categories of pathways.

**Choice-** *“if, at any point, the person indicates making a decision that they want, or at least explicitly agree, to seek care...individuals report, at minimum, active agreement with and often active participation in their use of health services,”* (p. 277, 280). Subcategories included **supported choice**; *“rational choices as embedded within a social network process,”* (p. 280) and **individual choice**, *“respondents describe making a decision on their own to seek help,”* (p. 280).

**Muddling Through-** *“individuals end up in mental health treatment though they indicate neither an active choice nor any resistance in their stories. In some cases, respondents are unclear as to how they got into the mental health system at all... often it was difficult to uncover where the muddling individual stood on the issue of treatment since they told their story as bystanders to the decision-making process,”* (p. 277, 281). Subcategories included **muddling through with an agent** *“strong, central agent from respondent's social network may ‘take over’ the situation. Likely to be someone who the individual's other ties as having the most*

*relevant experience and information,”* (p. 282) or **muddling through without an agent** “*no clearly discernable agent. Lack of agency... challenges both the decision-making and coercive views of system entry... nowhere in these stories did respondents portray an active resistance to care nor did they indicate that they agreed with or actively consented to care,*” (p. 282).

Within muddling, individuals that were offering assistance or directing participants through care did so in a way that was seen as helpful or neutral, not in a forceful or pressured way.

**Coercion-** “*reflect an active resistance to treatment throughout the story... active negation of the role of the individual. Social control, rather than free choice, is the dominant mechanism that pushes the patient into the health system. Through some combination of family, friends, employers, judges, and police, these individuals come into treatment despite their continual and active resistance,*” (p. 277, 281). Subcategories included **soft-coercion** “*extra-legal,*” (p. 281) and **hard-coercion** “*legal... prototypical cases of hard coercion involve family, judges, lawyers and police... coworkers or supervisors- they had some degree of “official” power to compel care seeking, even when the respondent resisted,*” (p. 281).

In her original work, Pescosolido noted classification may involve some subjective decision making to determine the final pathway classification (e.g., degree to which individuals actively participated in seeking or resisting mental health treatment to distinguish muddling accounts from choice or coercion accounts; p. 281). While collecting information for the operational definitions, a hierarchy of categories appeared to emerge; if participants expressed any sort of willingness or choice, they were classified in the ‘choice’ category, regardless of if they had indicated ‘muddling through’ or ‘coercion’ throughout their interview. This was noted as a ‘rule’ for classification of choice pathways within the original work by Pescosolido: “if at any point the person indicates making a decision that they want, or at least explicitly agree, to seek care,” (Pescosolido et al., 1998, p. 277). Those that expressed ‘coercion’ and ‘muddling through’ throughout their journey were classified in ‘coercion,’

and anyone that did not have any suggestion of willingness ‘choice’ or resistance ‘coercion’, were classified as ‘muddling through.’

Once I developed the operational codes, I presented them to the research team (Drs. Corey Mackenzie, Lesley Koven, Kristin Reynolds, and Genevieve Thompson, as well as a research assistant, Heather Hughes) for consideration, and I then coded transcripts. As coding progressed, I recruited Heather to code transcriptions for the purpose of comparison. Heather coded a total of 10 transcripts, which sampled from across all three original studies, and codes were reviewed together to assess reliability. Inter-rater reliability was calculated between each transcript, then averaged across all ten transcripts, for an overall inter-rater reliability of 87%. The majority of differences between the transcripts related to omissions or extraneous coding, rather than coding the same passage in two unique categories/sub-categories. Each differing code was reviewed together and discussed until agreement of code was reached. Drs. Mackenzie, Koven, and Thompson were also included for consultation to discuss specific quotations that did not fit cleanly into a pathway description.

For objective two (i.e., exploring whether the pathways should represent distinct treatment journeys of choice, coercion, *or* muddling through, or if they are best conceptualized as co-occurring processes within one’s help-seeking journey), I used conventional content analysis. Conventional content analysis is appropriate when previous literature is limited, and researchers are interested in immersing themselves into the data to develop new insights (Hsieh & Shannon, 2005). Within this type of content analysis, the study objective for analysis is said to start with an observation, which in this study is the difficulty (and potential lost details) in classifying participants into one of the three pathway categories (Hsieh & Shannon, 2005). In order to explore this objective, additional information would need to come from the data. For this analysis, the codes from objective one were utilized, with additional reflection on the words participants used, and the implications attached to their help-seeking journey. For each participant, I looked for, and analyzed, the following information, along with the pathway codes: the involved members of the help-seeking process, the number of steps (or treatment

providers) to the final psychology clinic, whether or not a referral was made, who suggested the initial idea to seek mental health treatment (and if it was not the participant, if they noticed the need for help or not), and the words participants used to describe the treatment-seeking process. Additionally, I reviewed the number of codes in each of the categories, and looked throughout the transcripts to determine any patterns in the participants experience. Some participants' patterns were very basic, consistently one or two codes, while other participants experience was described with most codes. Patterns in behaviour were also examined to determine changes in codes, for example, if participants became less choiceful every time they met with a medical professional.

**Trustworthiness.** Throughout the analysis process, I implemented several checks recommended to increase trustworthiness in the findings, including an audit trail and the discussion of codes and ideas with colleagues (Pope et al., 2000). Additionally, to increase objectivity, I used Pescosolido's definitions for codes to explore objective one, and factual questions (based on what participants specifically said, rather than my interpretation) were used for analysis of objective two, rather than imposing my own speculations (Graneheim, Lindgren, & Lundman, 2017). Trustworthiness has also been described in relation to the sample used for the study, that their recruitment and participation is also appropriate. Although not controlled within this study, participants were recruited for the original three studies from clinics that were appropriate to my target population (outpatient psychology clinics serving older adults, based in Canada), and were able to share their experiences to aid in answering the research objectives (Graneheim, Lindgren, & Lundman, 2017).

**Audit trail.** I maintained an audit journal throughout analysis, to document all procedures and decisions including initial ideas, and rationales for decisions, to provide a clear, traceable record of how I started from the original transcripts and ended up with the final codes. I used NVivo for data organization, which also provides an audit trail, designating codes and timestamps for all work completed.

**Consultation.** The research team included Drs. Corey Mackenzie, Lesley Koven, Kristin Reynolds, and Genevieve Thompson, as well as a research assistant, Heather Hughes. Drs. Mackenzie and Reynolds are two of the principle investigators of the three original studies from which data is being extracted, while Dr. Lesley Koven is a collaborating clinical psychologist on all three projects. It was important to include these individuals in the research team due to their experience and knowledge in this subject area, in addition to their familiarity with the data (Beatie, 2016; Reynolds, 2016). Dr. Genevieve Thompson, an Associate Professor from the Faculty of Nursing with extensive experience in qualitative research with older adults, provided an unbiased perspective as she was not a primary investigator on the three original studies. Furthermore, working with a research team in a collaborative approach has been deemed to increase consensus through processes such as coding difficult help-seeking journeys, and interpreting the data (Erlingsson & Brysiewicz, 2017; Graneheim, Lindgren, & Lundman, 2017; Pope et al., 2000). Bringing a team together with individuals from different backgrounds has also been recognized as a way to enhance study rigour, and to create a more dependable and confirmable set of findings (Erlingsson & Brysiewicz, 2017; Ward et al., 2013).

To supplement the interview data, I consulted the remaining collected data (demographics, health information, and field notes) to provide additional information about the participants. Field notes were reviewed and consulted alongside the interviews, because they captured the interviewers' perspectives of participants at the time of interview (details that are otherwise missed by using secondary data). Information from field notes was used to supplement participants transcripts; for example, in one transcript the participant did not state a mental illness diagnosis, however they provided this information to the interviewer outside of the interview, and this was noted within the field notes. The remaining supplementary data (demographics, and health information) were reviewed separately from the interviews, as information used to gain a better understanding of the sample.

## Findings

Participants included 35 older adults; a summary of their demographic information is found in Table 1. Participants were, on average, approximately 70 years old, female, married, White, and retired from work. Participants across the three original studies were not reliably assessed for diagnosis. However, although seven of 15 participants in Reynolds' study self-reported a diagnosis. These individuals, in addition to participants from Beatie (2016) and Mackenzie et al., (ongoing) formed the majority of the sample ( $n = 19$ , 54.7% reporting a mental health diagnosis), however that number may be higher. Regardless of whether participants had received a diagnosis or not, all participants were asked their reason for seeking treatment. Although some participants listed one reason for seeking treatment (usually their diagnosis or, for those without a diagnosis, most often it was solely caregiver stress or anxiety), many participants mentioned a combination of reasons for seeking services.

### Choice, Coercion or Muddling Through

Utilizing the operational definitions of the six codes, (individual choice, supported choice, hard coercion, soft coercion, muddling through with an agent, and muddling through without an agent), I coded the transcripts. Whenever participants provided a description of the events or decision process leading up to entering mental health treatment, that sentence (or sentences) was given a code. Participants ranged in the number of times they spoke about their entry to treatment, (from one to fifteen times), throughout their interviews. Once all transcripts were coded, I reviewed each transcript individually to determine the overall pathway codes, which are presented in Table 2.

**Table 2.** *Pathway categorization (n = 35)*

<i>Pathway Categories</i>	<i>n (%)</i>
Choice	21 (60%)
Individual	6 (17.1%)
Supported	15 (42.9%)
Coercion	0 (0%)
Hard	0 (0%)
Soft	0 (0%)
Muddling Through	14 (40%)
With an Agent	13 (37%)
Without an Agent	1 (2.9%)

The majority of participants entered treatment through some decision or willingness (*choice*), and of those individuals, the majority of them involved others (generally family, friends, and medical professionals) in the decision to access treatment. Within this sample, there were no participants who had pathways into care where the dominant theme involved resistance or being forced into seeking care (*coercion*). Some participants described certain aspects of their treatment journeys that involved feeling pressured. However, when accessing treatment, these participants ultimately described doing so willingly, so their transcript was coded as *supported choice* (to acknowledge the role that social others played within the treatment-seeking journey), while also capturing the willingness to access treatment. Finally, the remaining participants reported paths into treatment that featured neither willingness, avoidance, or recognition of the need for treatment (*muddling through*).

**Choice pathway.** Some participants indicated that the choice to access care was made on their own (*individual choice*), such as one Mary who sought support for her comorbid anxiety and depression who said: “*Well I felt that I needed some counselling... I actually wanted it, yeah.*” (Mary, 78). Some participants described the involvement of others in their treatment-seeking journey, however they described taking the initiative, or using others (especially primary care physicians), as a way to access the care they specifically wanted (*individual choice*). One such case was Ken who was seeking care for his anxiety symptoms, who described his journey as “*mainly self-driven*” but utilized

his primary care physician for a referral once he located the services he felt would be most appropriate for him:

*“I think I got uh, I think it was my family doctor eventually who referred me to [a clinical psychologist] but um I was the one that found uh an article about her program in the Free Press and then I had to mention to him... I told him about this program I said what do you think about it being appropriate and he said oh sounds good to me so gave me the, the referral so long as everything was, was me doing something about it” (Marty, 67).*

Participants were categorized as *supported choice* if the involvement of others held some weight, guidance, or importance in the decision to access care, or if participants did not take complete ownership of the need to access treatment, but still expressed an agreement or willingness. For some participants, support came from one or more individuals within their social network (i.e., family, friends, colleagues), while others had medical professionals or organizations that were an important part of their pathway to care. Beth spoke about getting support for caregiving stress through an organization providing support for her husband:

*“I guess we were recommended to the Alzheimer’s Society quite a while ago, maybe a year and a half, two years, and they accepted us and we’d go down every week for lectures, and it was a wonderful experience. We had group therapy, both my husband and I, and then he continued with weekly visits and I would go and we’d have coffee with the caregivers, chit chat and have a chance to compare notes or get ideas of how to go on with our lives. It was very successful and then through there, I guess, [a psychologist] was recommended and I called and I was accepted and I think I’ve been going to her for maybe three months.” (Beth, 81).*

Another participant, Ken, received a recommendation to seek additional psychological support from the psychologist he saw through a cardiac rehabilitation program;



*“Um, to seek help I think it was a joint thing between the psychologist and myself. As for this particular [clinic], I think it would be the same sort of thing. He recommended [the clinic] and it seemed like a logical choice. I tend to rely on the judgement of people who are expert in the field that I am looking at. The analogies that I keep using is that I don’t seek legal advice from my dentist... I think the entire process has been very respectful on the part of the people that I was dealing with and their recommendations were treated as recommendations and I could either accept or deny but it was obvious that their opinion was that I should seek treatment. I value that sort of approach in people so I followed up on it.” (Ken, 62).*

Here, Ken recognized his ability to agree, or disagree with his psychologist, rather than feeling obligated to receive additional care; he demonstrated his willingness and trust by following the psychologist’s recommendation. By indicating it was ultimately his choice, and not that he felt he was forced to follow through with the psychologist’s suggestions, he was classified as *supported choice*. At another point in the interview, Ken was asked to think about coming into care as an analogy to ‘driving in a car.’ When asked to describe where he was ‘seated in the car,’ he included his psychologist and wife as support, *“I would say that I was in the front seat but I wasn’t driving. [Who was driving?] I would say the psychologist. Yeah, my spouse would have been in the backseat providing support”* (Ken).

Often the decision about how to best classify pathways was a difficult one. One participant, Susan, described her treatment-seeking involving both *soft coercion* and *supported choice* and, in the end, I chose the latter category.

*“No I wasn’t reluctant at all... They weren’t influencing me to get treatment. I had a feeling that during this period of time they were trying to deem me incompetent... I felt that I had to prove that I wasn’t crazy”* (Susan, 82).

Typically, *soft coercion* includes participants expressing a disinterest or resistance in seeking treatment but were feeling pressured by family or other legal sources, while those classified as

*supported choice* have others involved in their treatment-seeking experience in an encouraging or helpful manner. In this individual's case, she described pressure from her family members to attend treatment, but she herself was interested in pursuing treatment, and saw going to therapy as a way to prove them wrong, rather than a deterrent from treatment. In this way, the family members' pressure was more supplementary to the participant's choice to seek treatment, even if it wasn't 'encouraging or supportive.'

**Coercion Pathway.** Although there were no participants whose pathways were clearly defined by a refusal or unwillingness to access care (which was why they were classified in pathways other than *coercion*), there were some descriptions of pressure or coercion discussed by participants within the interviews. One such participant, Caroline, felt pressure from her family members (*soft coercion*) to access treatment for her PTSD;

*"I need to get off of this [medication], my husband has had enough, my sister is telling me 'What the heck is going on with you? You are not the same person' ... He was at the end of his rope so to speak and he was frustrated with me and he was saying you aren't helping yourself. And I was like well I am. I'm going to the doctor and I'm talking to her about being depressed. And I'm going to see a counsellor," (Caroline- 62).*

Because Caroline willingly sought treatment, she was not coded as a coercive pathway, despite having some instances of pressure on her pathway to care.

**Muddling through.** After choice, muddling through was the next most common type of pathway described by participants. Many participants were classified as *muddling through with an agent*, as they entered treatment at the suggestion or recommendation of someone in their social network, usually a medical professional, without awareness that mental health treatment would be worthwhile. The following participant, Erica, was so consumed by her physical ailments and concerns that she did not recognize that she was also in need of mental health help. It wasn't until her doctor suggested she seek treatment, that she considered accessing psychological treatment:

*“I ended up in such terrible shape that I went to see my family doctor. It wasn’t even for that it was probably something to do with my surgeries. She took one look at me and she said ‘I think that you should go see a psychiatrist. You have been through too much.’ She asked me if it was alright. I said ‘Yes, I think I need it.’ ... I’m not sure why I went to go see my family doctor... but it wasn’t about going to see a psychiatrist,”* (Erica, 71).

Other participants indicated no recollection of discussing seeing a psychologist, nor any details in arranging such treatment with their family physicians. Mabel (83), said *“I don’t know, I, I didn’t seek out [a psychologist] for some reason we were just connected”*. Another theme found within the *muddling through with an agent* codes, was that someone other than the participant assumed responsibility for getting help, including things such as making a request for service and setting up initial appointments, as was the case with Caroline:

*“I didn’t have to do anything myself. She made the referral to [the psychologist] ... It was still several months. I kind of put it behind me like if I hear, I hear, if I don’t, I don’t. Then I got a call from the office that they had my appointment”*.

A similar experience was reported by Steve (87) who was connected to services by a family member, rather than seeking services out himself: *“I don’t know how [my daughter] found [a psychiatrist] but she did and it was through her that I got connected [to the psychologist]”*.

The final category was *muddling through without an agent*, in which participants came to treatment by way of another type of service or treatment directly referring them, or in transitioning themselves to another type of service or medical care. For example, Erica was referred from their family doctor to a psychiatrist resident. When the resident moved to another placement Erica was transferred to the clinical psychologist’s office;

*“I had to wait until the end of January and I saw a doctor who is a resident psychiatrist and she takes people on an interim basis as part of her training so I saw her from January 18th until the end of June ... So she said “I am finished at end of June. Do you think that you would like to*

*continue?” I said “Yes. I think that I need it.” That was organized already ahead of time so before I think it was two or three months into our meetings I got a call from [psychologist] that I was referred to her. So everything was set up and ready to go when I finished my sessions with [the psychiatrist]” (Erica).*

Other participants expressed a more difficult journey in seeking the right kind of treatment for them, or getting lost in the medical system without the ability to get the help they needed quickly;

*“And you know I phoned uh health links or you know that yea, and they said oh don’t bother because uh we can’t really help you too much, you have to go one of these places in the newspaper because uh it’ll be seven or eight months before you can go see a psychiatrist so uh that’s your best option. And after that so I went to [my family doctor] and I asked him and he say, well I had been taking depression pills before that, but uh then I asked him for an increase in my pills so he said well I can’t give you, you’re taking the maximum now you can’t take any more. I said well I need help, and he says I’m reluctant to have you go to a psychiatrist because uh I don’t want you to take any of that strong medicine. And so he says try taking uh the citalopram half in the morning, half at night to even it out, but that didn’t work very well. And uh the only thing that got me to ... the psychiatrist was, uh, I went to a thing for my pacemaker. The doctor there [cardiologist] uh she looked at my prescription says oh, citalopram so you have some depression. I said I have a terrible time with depression. And [my wife] says he really suffers with it. She [cardiologist] says I’ll look after this and within a week or so I had my appointment [with the psychiatrist]” (Jim, 75).*

Following this experience, Jim was connected with a psychologist to supplement his pharmacotherapy, adding an additional step in his treatment journey. Throughout the experiences of *muddling through*, it was evident that participants relied on others in a neutral or supported way; these ‘others’ allowed participants a semblance of dependence, rather than force or a need to oblige. This was especially true of those in *muddling through with an agent*, where participants depended on the advice, skills,

connections, or expertise of those consulted with to provide them with access to mental health care.

For those classified with *muddling through without an agent*, a lengthy, and sometimes confusing, process was described, with multiple ‘stops’ in the pathway while participants waited for referrals, or accessed care at another type of service. Such services described included family physicians, counsellors, community programs/organizations and not-for profits, and psychiatrists. Although some participants had accessed care for mental health concerns in their past, to be coded as *muddling through without an agent*, the services attended needed to be connected to this current instance of accessing care, and not including a previous instance of mental health treatment.

### **Choice, coercion, AND muddling through**

Following the coding for objective one, I reviewed participants’ complete transcripts to assess their overall pathway experience. Findings related to objective two demonstrated that many participants held variations in their pathway, rather than a defined singular route (Table 3).

**Table 3.** *Breakdown of choice, coercion, and muddling through code patterns (n = 35)*

<i>Number of pathway categories represented</i>	<i>n (%)</i>
One	<b>10 (28.6)</b>
Choice (SC)	1 (2.9)
Muddling (NL)	9 (25.7)
Two	<b>12 (34.3)</b>
Choice (IC & SC)	1 (2.9)
Muddling (WA & WOA)	5 (14.3)
Choice (SC) & Muddling (WOA)	2 (5.7)
Choice (SC) & Muddling (WA)	2 (5.7)
Choice (IC) & Muddling (WA)	2 (5.7)
Three	<b>9 (25.7)</b>
Choice (IC & SC) & Muddling (WOA)	2 (5.7)
Choice (IC & SC) & Muddling (WA)	1 (2.9)
Choice (IC) & Muddling (WOA & WA)	2 (5.7)
Choice (SC) & Muddling (WOA & WA)	4 (11.4)
Four	<b>3 (8.6)</b>
Choice (IC), Coercion (SCo), & Muddling (WA & WOA)	1 (2.9)
Choice (IC & SC) & Muddling (WA & WOA)	2 (5.7)
Five	<b>1 (2.9)</b>
Choice (IC & SC), Coercion (SCo), & Muddling (WA & WOA)	1 (2.9)

*Note.* Choice (IC) = Individual Choice; Choice (SC) = Supported Choice; Muddling (WA) = Muddling Through With an Agent; Muddling (WOA) = Muddling Through Without an Agent; Coercion (HCo) = Hard Coercion; Coercion (SCo) = Soft Coercion.

As shown in Table 3, only 10 of 35 participants' journeys represented only one type of code. For nine of those 10 participants, the entire description of their pathway to treatment reflected *muddling through with an agent*, and the other participant's pathway only reflected *supported choice*. The remaining 25 participants described a pathway that included more than one category of treatment-seeking that reflected a combination of *choice*, *muddling through*, and *coercion* code categories. For some six participants of the 25, despite more than one code being used, their pathways were similar. For example, one participant's pathway only described instances of *individual and supported choice*, while five participants *muddled through* their treatment-seeking journey, with codes from the *muddling through with an agent to muddling through without an agent* categories. Within these six participants'

journeys, the transition between different codes was reflective in the language used to describe the level of their personal involvement and direction, versus the involvement of others.

Throughout all the coded pathway categories, there were a range of explanations and descriptions of the process to access care. Some participants described a simple pathway, with a very clear entry; “[the doctor] asked if I wanted help and I told her yes and she was the one who recommended you know um whatever doctor for me to see,” (Lynn, 63) while other participants had a much more complex pathway, with descriptions that involved many of the different pathway types. For example, Caroline described the most complex process to access care, including the most code types within her help-seeking pathway (five out of the possible six). She noted that she came to seek treatment at the psychology clinic “by chance.” When first asking for support with her mental health, “the first doctor... prescribed me the venlafaxine, [and] asked me to go see this counsellor.” From there, she found it difficult to get off her medication, and didn’t find benefit from seeing the counsellor. Her family members noticed the change in her and put pressure on her to seek services, and she noted that she was already seeking services at this point. Following this, her treatment pathway stalled, as she weaned herself off her anti-depressants, switched family physicians, and stopped seeing the counsellor. Finally, in pursuit of physical health care, her pathway to mental health treatment was re-started;

*“So when I went to the [Hospital], I was referred to [a surgeon] downtown by my family doctor... Because I was going to the Vic, this is where he practices, I had to go through the pre-op questionnaire and on the form it says have you ever had problems with anesthesia or anesthetics and I said yes, I have. So, they had me go and sit with the anesthesiologist... A lovely young lady and she was asking me questions about anesthetic and what my experience had been and I told her some things and she said you could possibly be suffering from post-traumatic stress. I said ‘really because of this experience in 1980?’ Then I thought well I am quite open to finding out more about it and finding out whether or not there is a link between*

*that experience in 1983 to me struggling so hard with depression at certain times in my life being at an all-time low, being unable to cope, being unable to cope with my father's death in particular and I was quite willing to pursue it. That is how I ended up here."*

The anesthesiologist facilitated a referral to a psychology clinic, and Caroline reflected on pursuing treatment;

*"I think once the referral was made I was very much in control of I am going today or I am not going again. It really is up to me whether I continue to see [the psychologist]. I have always known from the beginning that a referral would be made but it was up to me if I want to go."*

Within her description, instances of *muddling through with an agent* ('by chance'), *soft coercion* (family pressure), *muddling through without an agent* (multiple service providers and treatment types), *supported choice* (discussing symptoms with anesthesiologist), and *individual choice* (deciding to follow through with referral) are all described.

The results in Table 3 indicate that participants described a range from one to five types of codes within their pathway to treatment, with the most common occurrence being two types of codes, followed by one code and three types of codes. Despite these variations, the muddling through codes were most common and were represented across almost all participants' descriptions. Following *muddling through*, the next common code was *choice*. Although there were more instances of muddling through within participants help-seeking journeys, these same participants often expressed a willingness or decision to access care at one point or another, which made their overall code categorization 'choice', as suggested by the rule from Pescosolido's original work. In consideration of this suggestion I re-examined each transcript to explore the effect using this rule had on the classification. Specifically, I was interested to see if classifying the participants as choice was an accurate representation of their entire pathway, or if it was a rare instance within their pathway and a different overall code may be more appropriate. Looking at the 21 participants who were coded as choice in the analysis for objective one, 12 participants out of the 21 would have been more



appropriately categorized as *muddling through with an agent* or *muddling through without an agent*.

Within these participants, although they expressed some willingness in accessing treatment, the majority of their pathways to treatment were directed by someone else, or they shifted around in the search of appropriate treatment, indicators of a typical muddling through pathway.

### **Discussion**

With the objective to better understand the help-seeking journeys of older Manitobans seeking treatment in an outpatient mental health clinic, compiling transcripts from three different studies allowed for a further exploration of the dynamic treatment-seeking pathways proposed by Pescosolido and colleagues in 1998. In comparison to Pescosolido's sample, which was recruited primarily through inpatient psychiatry units and required a diagnosis of severe mental illness (i.e., bipolar disorder, major depression, or schizophrenia), the older adults in this study experienced a wide range of mental illnesses, and many participants sought outpatient treatment for subclinical concerns. Additionally, participants in the current study sought treatment for comorbid physical health concerns and caregiver stress more frequently than concerns more commonly encountered earlier in life, such as addiction and family stress (Fiest et al., 2011; Pinguart & Sörensen, 2003).

Likely as a result of differences between Pescosolido's (1998) sample of middle-aged, American inpatients with severe mental disorders and the current study's sample of older, Manitoban outpatients, I found differences in the pathways to treatment. Within both studies, the most frequently reported pathway was choice, followed by muddling through, and then coercion. Participants in the current study were more likely than in Pescosolido's to be categorized as having a choiceful pathway, and they were also more likely to be classified as muddling through. Pescosolido's descriptions of muddling through included two severe instances with "another family member taking over the situation" and bringing people into treatment. These two situations included one participant who was in the process of suicide by overdose, and another who was in a psychotic state. I found no evidence of this type of extreme muddling in the current older adult outpatient sample. Instead, muddling through

with an agent typically involved someone making the suggestion or referral, or bringing the need for treatment into the participant's awareness. These participants relied heavily on referrals, however they ultimately agreed with the suggestion to pursue treatment, reflecting pathways categorized as supported choice. Unlike in Pescosolido's inpatient sample where approximately a quarter of participants had a pathway categorized as coercive, no participants in the current study described an active resistance in seeking help. Although two participants did describe pressure from family members, they willingly accessed treatment at the same time the pressure was occurring and were therefore categorized as supported choice. Again, this difference is likely attributed to the type and severity of mental health problems reported among the samples, to the clinics where participants were recruited (i.e., inpatient versus outpatient), and to the differences in age between the samples. This finding runs counter to other research which has found that older adults are more likely to seek treatment in response to pressure or family concern, even when they themselves don't see the need to access it (Emiliussen, Andersen, & Nielsen, 2017).

The ability to accurately categorize participants' pathways into one of the primary codes was difficult for a number of reasons. One reason involved participants' ability to accurately recall specific aspects of their pathways into treatment and the length of time between initially accessing treatment and completing interviews. When considering the populations within the two studies, some researchers suggest that older adults may misremember details due to a poorer episodic memory (Jeste et al., 1999; Streiner et al., 2006). Misremembering is also more likely when individuals are under heightened levels of stress, which they likely were at the time of seeking help, however this would be present across both populations, especially for those participants from Pescosolido's (Pescosolido et al., 1998) study who entered treatment in a psychotic state. Additionally, participants of the current study were more likely to have a longer time between their treatment entrance and the time of interview- (sometimes up to several months after entering treatment) than those interviewed for Pescosolido's study, which could make it difficult to remember or distinguish the details of help-seeking, especially

in a semi-structured interview format. All of these factors could have impacted the classification of pathways if participants described their entry into care in a way that was different than what really happened (for example, if they forgot that they had asked for a referral, and instead stated that the doctor suggested they seek mental health help, they could be classified as muddling through, rather than choice).

Another reason why it was difficult to code participants' pathways, as described by Pescosolido and colleagues (1998), is the theoretical overlap between categories. For instance, some participants described experiences with others that included elements of coercion and supported choice, wherein there was pressure from others, but the participant entered treatment willingly, with little suggestion of the impact of the pressure. Although the term supported choice doesn't seem appropriate to describe these instances, Pescosolido and colleagues used the term 'supported' to represent the engagement of the social network, even though the title itself implies assistance or encouragement from the social network. When considering the definition put forward, "rational choices embedded within a social network process" (Pescosolido et al., 1998, p. 280), someone from the social network *helping and supporting* isn't required to meet the criteria of a decision embedded within the social process. Therefore, I considered such descriptions supported choice. Additional difficulty with categorizing participants' pathways included the use of others as a referral source. For some participants, there was a deferral to others; in many cases, to medical professionals. For others, a referral acted as only one unique feature in an otherwise individual approach to treatment decision making. Therefore, those who depended more on the advice of the medical professional to make decisions were seen as muddling through with an agent, while others who depended less on the advice of the medical professional were identified as supported choice.

As per Pescosolido's description in her original work (1998), if participants ever expressed an instance of willingness or unwillingness to seek treatment, they were to be categorized in the choice and coercive pathways respectively, regardless of the other aspects of their journey to treatment.

Although the final use of choice or coercion captures the intention of participants accessing treatment, it excludes details from the rest of their pathway. I was interested to explore these transcripts without Pescosolido's rule. That is, I wanted to examine which codes were most representative of the help-seeking pathway, rather than willingness alone. Looking at participants who were categorized in the choice pathway, the majority of those individuals would have been more appropriately categorized as muddling through with an agent or muddling through without an agent if it was not for the guiding suggestion in Pescosolido's original work. Participants' discussion of pathways that included descriptions of both choice and muddling through was not rare. In fact, it was more typical to see examples of more than one type of pathway within each participant's descriptions.

When considering the classification of individuals' help-seeking journeys, selecting one of choice, coercion, or muddling through when elements of the others were present seemed to omit important information that could be useful for treatment planning and system support for those accessing treatment. Very few of the participants in this study had only one 'steady' path to treatment, and the majority moved across a continuum from muddling through to choice, with a few instances of coercion mixed in for some individuals. When investigating participant's experiences, a common pattern was for individuals to begin their journeys by muddling, and they often remained there until they spoke of their acceptance and willingness, or resistance or pressure, that signaled a change in their pathways toward choice or coercion. We therefore lose important information when we reduce pathways to being 'choiceful' or 'coercive.' It is obviously advantageous to capture, for example, this interesting and common path involving an initial period of feeling unsure or lost, getting bounced around in both helpful and unhelpful ways between formal and informal sources of support, and eventually coming to an appropriate treatment.

By categorizing participants based on solely their willingness (as represented by choice or coercion), a crucial aspect of the help-seeking process may be left out- the actual **process** of how individuals get help, which is what the muddling through category captures. As seen within the

transcripts, these different pathways to care do not exist exclusively, and can overlap not only within the journey to care, but also in time. Participants within the study demonstrated that it is possible to be willing to seek treatment, but not be driving the help-seeking process. These participants commonly got lost within, or bounced around, the health care system before they eventually made their way to a clinical psychologist. Although it was not represented within this sample, individuals who are unwilling or uninterested in receiving treatment, would not be the active driver in their treatment-seeking process. They could be bounced around the mental health system as well, if they transitioned between services, as seen in the sample, or saw multiple treatment providers at the same time (e.g., psychiatrist, psychologist, family physician).

With respect to the second objective of this study, to conceptualize a more dimensional way of capturing an individual's pathway, I first considered what may be important to know about the journey to care. Certainly, as a clinician knowing whether clients are coming to treatment willingly or not holds useful information about treatment motivation, and in mapping a course for treatment. For example, knowing whether clients are entering treatment choicefully or not suggests a possible difference in the degree to which he or she will be an active agent in their own care, or if treatment might benefit from involving others for support. Additionally, the benefit of knowing if clients recognized the need for mental health help may provide insight into the amount of psychoeducation they need about their symptoms, as well as how to best structure therapy sessions and homework, (e.g., including more analogies, or providing additional reading material at the onset of treatment). Additionally, understanding if clients got lost within the mental health system, or were coming to you as a last resort after many months or even years of drifting around the treatment system would provide further insight into client frustration and fatigue, which could help clinicians modify how much time and effort is required at the start of treatment to work effectively with that client. All information regarding the pathway to care could serve to strengthen therapist-client relationship, which has been

recognized as a facilitator to accessing and staying involved in treatment, or as a barrier if clients view their relationship with their therapist as poor (e.g., Ryan, Lynch, Vansteenkiste, & Deci, 2011).

Understanding how individuals access care is also important in planning for, and evaluating the medical health system. Policy makers refer to the research literature to make decisions for health care system changes. If such research indicates that patients are accessing care decisively- through choice or hard coercive pathways- it would suggest the system is working appropriately to provide patients care when they need it. If the system appears to be working appropriately, it implies that lower levels of treatment-seeking may be due to patients not needing care, rather than difficulty with navigating the system itself. When looking at participants' journeys to treatment, we see that the process was generally not 'decisive and appropriate,' rather that the siloed health system did not encourage easy access into, or around the system for treatment. When help-seeking is defined by willingness, we lose the transitioning that is happening within care, as well as the fact that, in some cases, health professionals, family, and friends are taking over and leading patients through the system. Muddling shows that people are getting lost or bounced around in the system often - delaying the process because clients are unsure of who can help them, and sometimes waiting for referrals and services that are not appropriate or of interest to them (e.g., waiting for a psychiatrist despite being unwilling to take prescription medication). In losing the information about the process of help-seeking, the literature and research showing that certain populations, such as older adults, are having a more difficult time navigating care due to issues such as mental health literacy (e.g., Robb, et al., 2003) and perceived need for care (e.g., Cole et al., 2008; Mackenzie et al., 2012) is negated. Through this, we also diminish the need to work towards a more direct access pathway to care, and cut down clients' wait-time to receiving treatment.

Within the help-seeking research put forth by Pescosolido and colleagues, two types of classification have been suggested; the relatively intuitive and easy task of classifying the help-seeking pathway into choice, coercion, or muddling through; and a second more challenging and extensive

method, using the Network Episode Model- II (NEM-II; Figure 1; Pescosolido et al., 1998; 2013).

With the simple task of classifying participants into one of three pathways, clinicians and researchers can use minimal information- such as a few questions- to assess how clients came to access treatment. In contrast, to classify clients or participants based on the NEM-II, much more information is required to understand and classify the help-seeking journey, which is not very user friendly or efficient on the part of a clinician or researcher. Rather than being too simplistic in the classification of individuals into one of three pathways, help-seeking journeys can be seen as more dynamic and fluid, as demonstrated in objective two. By assessing clients' paths as choice, coercion, and muddling through, the task of treatment entry classification remains relatively simple and intuitive, but captures more of the variability of the pathway for a truer description of the individuals' important experience.

### **Limitations**

Several limitations concerning qualitative analyses of secondary data were already discussed in the introduction section. Additionally, as with much of the qualitative literature, there may be limitations of trustworthiness, specifically that the three original investigators utilized unique study protocols, and not all participants were met with the study conditions. Through prolonged engagement with the data and research team debriefing, attempts were made to increase credibility with secondary data analysis (Lincoln & Guba, 1985; Manning, 1997).

As demonstrated within the literature, older adults are less likely to access mental health services than their younger counterparts. Therefore, this study investigated a small portion (35 participants), of an already limited group of older adults (e.g., Cole et al., 2008; Crabb & Hunsley, 2006; Robb et al., 2003; Mackenzie et al., 2008) as the majority of older adults needing mental health care never seek or receive it. Despite this, it was important to add to the literature on geriatric help-seeking, to help improve the number of older adults receiving treatment. As noted within the literature, it can be difficult to recruit older adults for research, due to survey refusal and higher levels of study exclusions (Hocking et al., 1995; Streiner et al., 2006). Therefore, the particular research strategy was

selected to allow for a larger sample of individuals who have successfully accessed treatment. This can be seen as a limitation; the sample, which was conveniently collected from three clinical psychology clinics, demonstrates a more homogeneous sample (looking at Manitobans only) and only one specific portion of the help-seeking picture; I did not capture much of the available community services, inpatient care, successful in-office-only treatment within primary care facilities, or any other type of treatment centre (including other clinical psychologists). The sample did not capture those who had begun to seek care and dropped out of treatment, or were still navigating their help-seeking journeys. It did not capture those who are continuing on with their journey, either to new services, or with different providers. Older adults receiving treatment on inpatient units or for more serious mental illnesses may have included more experiences of coercion and pressure, and fewer experiences of muddling through and choice. Alternatively, recruiting participants from their family physicians' offices, prior to them accessing any other type of care would likely represent pathways of less choice, coercion, and muddling through without an agent, and more muddling through with an agent. Individuals in each of these settings may express differences in their pathway to treatment that I was not able to consider within this study. The sample was also homogeneous in relation to participant ethnicity. Although these findings from the current study may not generalize to all older Canadians with mental health treatment needs, this qualitative study was undertaken to gain an in-depth understanding of the current participants' experiences. By using a population where this model of help-seeking has not been explored, this study offers a perspective to help-seeking within older adults. Future research should continue to explore these factors within diverse populations (other underserved populations such as newcomers, homeless, LGBTQ, and Indigenous populations), to better capture the dynamic aspects of the pathway classification. This could be supported by the development of questions to assess pathway classification, as well as larger scale quantitative studies.



## **Implications and Conclusions**

With mental health problems affecting approximately 20% of Canadians within the past year (RiskAnalytica, 2011), and older adults being recognized as the least likely age group to receive mental health treatment (Crabb & Hunsley, 2006), it is important to explore and attempt to understand the negative relationship between age and help-seeking. Despite decades of research being devoted to help-seeking, the reasons why many older adults with mental health problems do not seek treatment are not fully understood. Although much is known about various individual barriers and facilitators to treatment-seeking (e.g., Andrade et al., 2014), the process of how these factors interact and impact individuals' help-seeking journeys over many weeks, months, or even years seems to still be missing. It was with this goal, to better understand individuals' complete pathways to care, that this study was developed. Using the three pathways introduced by Pescosolido and colleagues (1998), I found that older Manitobans' pathways to treatment were not only dynamic and multifaceted, there was support of the complex nature of the help-seeking journey as suggested by the NEM-II. Within participants help-seeking journeys, most participants expressed multiple pathway categories and sub-categories within their journey. The range in category types being captured within each participants' journey was from one to five of the possible six, however the majority of participants included two or three sub-categories within their help-seeking experience. In comparing these participants help-seeking journeys to that of original Pescosolido study (Pescosolido et al., 1998), a very different set of results were found. I found that older adults were more likely to pursue treatment through choice – especially supported by members of their social and treatment networks – and by muddling through the system, or having someone lead them to the appropriate services. Force and pressure was rarely seen, with only two individuals indicating soft coercion within their otherwise willing or muddling journeys. Many participants started their pathways in a muddling way- having their mental health needs pointed out to them by others- before changing to a pathway of willingness and choice. Capturing these pathways under the umbrella of a single descriptor such as choice or muddling seemed to wash away much of the

important, dynamic process involved in most participants' pathways to care. By focusing on each participants' journey as a whole, as well as consideration of each aspect of the multi-faceted pathway- by using choice, coercion and muddling through- a much richer and thorough description of the dynamic nature of the treatment-seeking experience of each participant was achieved.

Implications of this study's findings include the importance of increasing awareness for health care professionals that the help-seeking of older adults is dynamic with many factors contributing to seeking services. Often ideas of how to access care are convoluted, and care seeking may not be direct. Although many desire a simple method to encourage more help-seeking, the variation in most participants' pathways demonstrates that this may not be possible. However, the fact that muddling through is captured in the majority of participants' help-seeking journeys should be considered and addressed within the health care system to offer support to simplify and encourage choice in the treatment-seeking process. These changes may also encourage others to seek treatment or support services, especially for those who hesitate or choose not to access treatment due to the uncertainty or confusion of the health care system. An increased awareness that there is not a 'one-size-fits-all' approach to getting into needed care may also be useful for family members, policy makers, and key stakeholders who are tasked with supporting the growing numbers of older adults with mental health problems. For clinicians and those working with older adults regarding their mental health, asking about, and understanding the factors relating to their treatment-seeking may help foster stronger connections to enhance mental health treatment outcomes, direct them to the most appropriate type of care, and provide an increase in their mental health literacy, aiding in their own treatment and that of their peers. It is through this heightened understanding of the dynamic nature of help-seeking that we can aim to support older adults, when they need it most, on their pathway to mental wellbeing.

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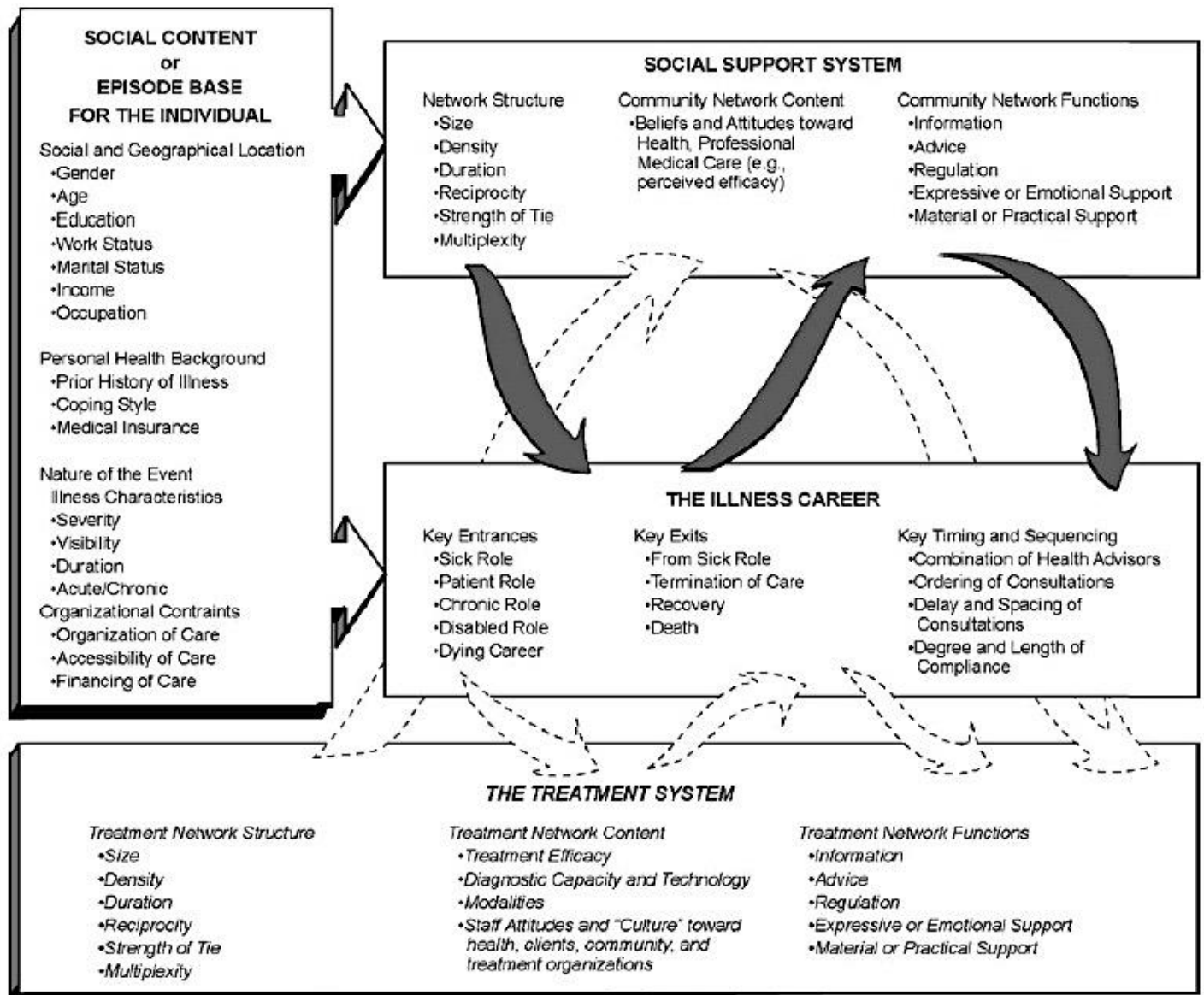


Figure 1. The Network Episode Model II, developed by Pescosolido and colleagues in 2013.

**Appendix A****Pre-Interview Questionnaires  
(Reynolds, 2016)****Today's Date:** \_\_\_\_\_**Age:** \_\_\_\_\_**Gender:** \_\_\_\_\_**Highest level of education:** \_\_\_\_\_**Current occupational status:** Full-time  Part-time  Retired, from what: \_\_\_\_\_**If you are currently retired, how long have you been retired?** \_\_\_\_\_**Current Household income:** \$0 - \$19,999  \$20,000 - \$34,999  \$35,000 - \$59,999  \$60,000+**Marital status:**  Single  Common law  Married  Widowed  Separated  Divorced**Race/Ethnicity:**

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

**Other:** \_\_\_\_\_

**Appendix B****Interview Protocol  
(Reynolds, 2016)**

1. What brings you in for treatment at St. Boniface Hospital?
  - a. How did you decide to see a psychologist for help with X (problem identified in question 1)?
2. Tell me about the time when you first noticed that you were experiencing X
  - a. Tell me about how you recognized that this was something that you needed help with.
  - b. 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)
  - c. Was there anyone who was unhelpful in this process? (Probe for personal, familial, and systemic obstacles/challenges)
  - d. Was there anything that helped you to recognize that you needed help and helped you to find help?
  - e. Was there anything that was unhelpful in this process?
3. Is this your first time seeing a psychologist?
  - a. Is this the first time that you noticed that you were having a hard time coping with X (problem identified in question 1)?
  - b. If you have had difficulty coping before, what stopped you from getting help at that time? What was different about this time?
4. What did you know about therapy before coming to St. Boniface Hospital?
  - a. What would you have liked to know?
  - b. What are you hoping to gain from therapy?
5. Is there anything else that you would like to say before we end the interview?

## Appendix C

Pre-Interview Questionnaires & Mental Health Throughout the Lifespan Graph  
(Beatie, 2016)

## Background &amp; 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 at 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

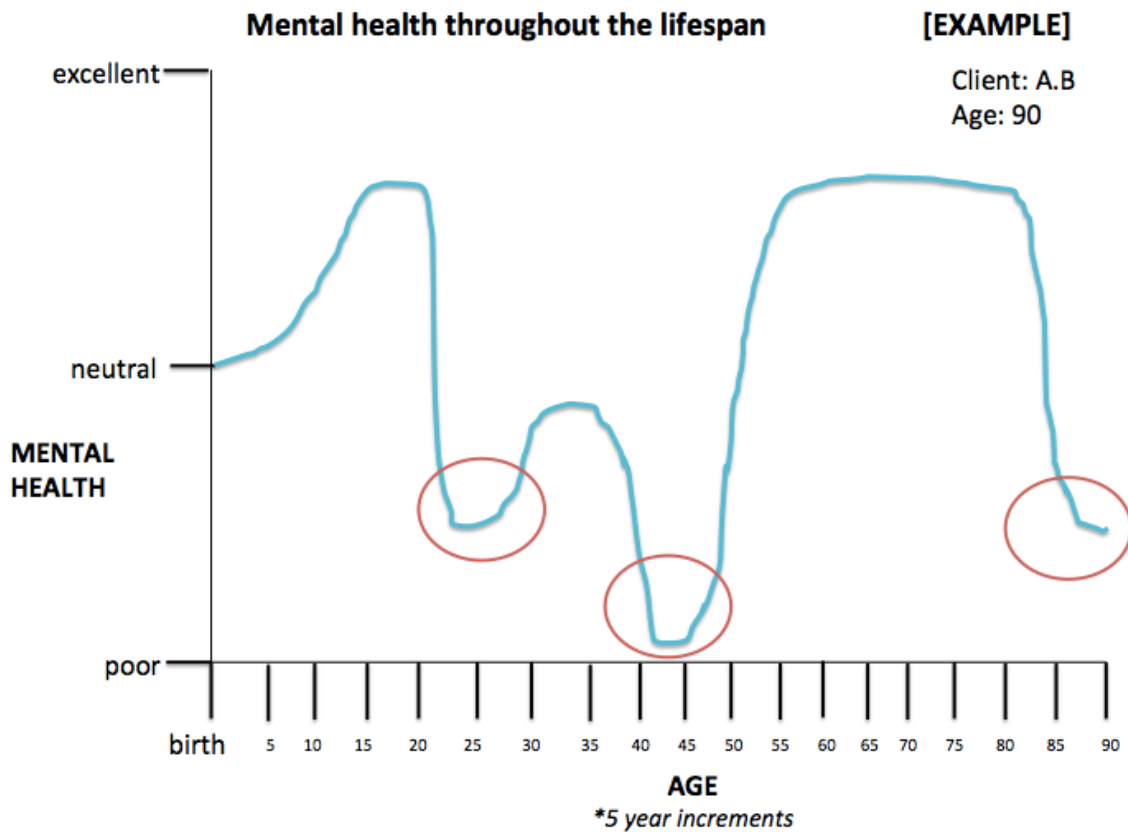
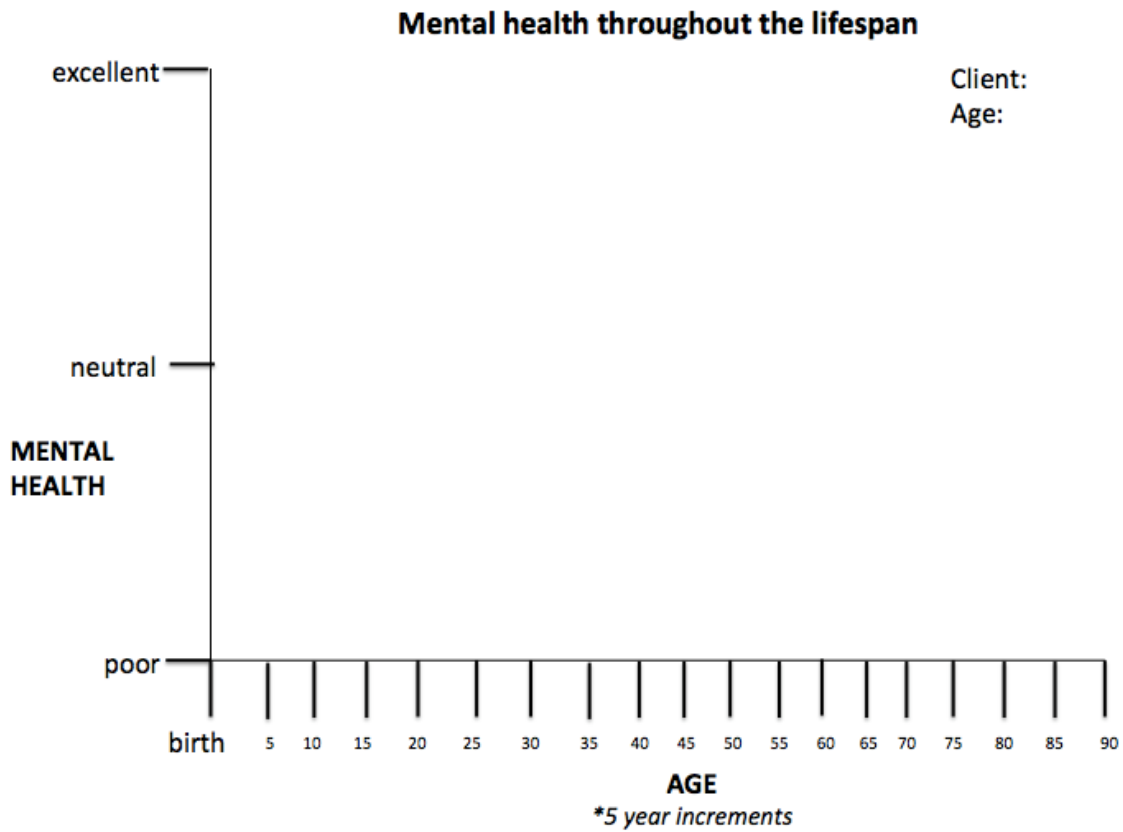
6. How many friends do you feel at ease with that you can talk about private matters?

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"/>

**Mental Health Lifespan Graph**



**Appendix D****Interview Protocol  
(Beatie, 2016)**

*\*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.*

**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?

**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. 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. Are there any other professionals you are seeing for services regarding X [mental health problem that clients are in treatment for]?**

b. How are these other professionals helping you?

c. What treatments are you getting?

**PAST EXPERIENCE**

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

**Illness career (5 mins)**

**11. 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 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 E

### Pre-Interview Questionnaires & Mental Health Throughout the Lifespan Graph Mackenzie et al., (ongoing)

#### Demographics Survey

*For questions with no answer options, please fill in the blank. For questions with multiple choice options, please select the option that best satisfies your response.*

**What is your age?** \_\_\_\_\_

**What is your gender?** : Female \_\_\_\_ Male \_\_\_\_ Other (*Please specify*) \_\_\_\_\_

**What is your first language:** English \_\_\_\_ French \_\_\_\_ Other (*Please specify*) \_\_\_\_\_

**Please select *one* ethnicity from the following options that best fits you:**

- \_\_\_\_\_ White
- \_\_\_\_\_ Indigenous (First Nations, Métis, Inuit)
- \_\_\_\_\_ Chinese
- \_\_\_\_\_ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- \_\_\_\_\_ Black
- \_\_\_\_\_ Filipino
- \_\_\_\_\_ Latin American
- \_\_\_\_\_ Arab
- \_\_\_\_\_ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
- \_\_\_\_\_ West Asian (e.g., Iranian, Afghan, etc.)
- \_\_\_\_\_ Korean
- \_\_\_\_\_ Japanese
- \_\_\_\_\_ Other – Please specify: \_\_\_\_\_

**Which setting best describes where you live?**

Urban \_\_\_\_\_ Rural \_\_\_\_\_

**What is the highest level of education you have achieved?**

- \_\_\_\_\_ Some high school
- \_\_\_\_\_ High school, or equivalent
- \_\_\_\_\_ Some college, no diploma
- \_\_\_\_\_ College diploma or trade/technical/vocational training
- \_\_\_\_\_ Some university, no degree
- \_\_\_\_\_ Some university, currently attending
- \_\_\_\_\_ Bachelor's degree
- \_\_\_\_\_ Master's degree
- \_\_\_\_\_ Doctorate degree

**What is your current occupational status?**

Full-time \_\_\_\_ Part-time \_\_\_\_ Retired \_\_\_\_ Unemployed/on Disability \_\_\_\_  
Student \_\_\_\_

**What is your marital status?**

Single \_\_\_\_ Dating \_\_\_\_ Married or Common Law \_\_\_\_ Widowed \_\_\_\_  
 Separated or Divorced \_\_\_\_

**Approximately what is your current household income before taxes?**

\_\_\_\_ \$0 - \$9,999  
 \_\_\_\_ \$10,000 - \$19,999  
 \_\_\_\_ \$20,000- \$29,999  
 \_\_\_\_ \$30,000 - \$39,999  
 \_\_\_\_ \$40,000 - \$49,999  
 \_\_\_\_ \$50,000 - \$59,999  
 \_\_\_\_ \$60,000 - \$69,999  
 \_\_\_\_ \$70,000 - \$79,999  
 \_\_\_\_ \$80,000 - \$89,999  
 \_\_\_\_ \$90,000 - \$99,999  
 \_\_\_\_ \$100,000 - \$149,999  
 \_\_\_\_ \$150,000+

*We would now like to ask you some questions about your current mental health concerns and mental health treatment.*

**Please select the clinic that you are receiving treatment from:**

*(Where you would have learnt about the study from)*

\_\_\_\_ Anxiety Disorder Clinic  
 \_\_\_\_ Crisis Response Centre (CRC)  
 \_\_\_\_ Health Psychology Clinic  
 \_\_\_\_ Operational Stress Injury Clinic (OSI)  
 \_\_\_\_ Psychological Services Centre (PSC)  
 \_\_\_\_ St. Boniface Geriatric  
 \_\_\_\_ Student Counselling Centre  
 \_\_\_\_ University Health Service (UHS)

**Please state the reason why you are seeking help at this clinic:**

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**Have you received a formal diagnosis(es) for your current mental health concern?**

\_\_\_\_ No      \_\_\_\_ Yes

**If yes, what is the diagnosis(es)?**

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**If yes, who gave you the diagnosis(es)?**

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**Prior to visiting this clinic for your current mental health concern, briefly list any other mental health treatments you received, including but not limited to: treatment at a different clinic, or seeing a different type of professional (e.g. psychiatrist, general physician, alternative care healer, etc.)**

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**With respect to your current mental health treatment, would you say you:**

- Have not started yet  
 Recently started  
 Are part way through treatment  
 Nearing the end of treatment  
 Finished treatment

**If you have started treatment, approximately how many weeks/months ago did you start?**

- Less than a week  
 1-2 weeks  
 3-4 weeks  
 1-2 months  
 3-6 months  
 More than 6 months

*We would now like to ask you some questions about your previous mental health concerns and mental health treatment.*

**Have you sought treatment for a mental health problem in the past (prior to the problem you are currently seeking help for)?**

- No       Yes

**If yes, briefly indicate (as best as you can) what mental health treatments you received, and approximately when you received treatment. (For example, “my family doctor put me on an antidepressant for approximately 5-6 years, and I also saw a counsellor for one session last year”)**

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**If yes, briefly indicate whether you felt the previous mental health treatments you received were effective or not.**

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*For the next few questions, we want to know about the path you took that led you to this clinic. For some people, the path to receiving mental health services is relatively quick and direct, and for other people the path can be long and confusing. People also vary in terms of how much choice and control they feel they have while they are seeking help. We are interested in learning more about your experience.*

**When thinking about the path you took to access your current mental health services, circle the most appropriate response for each of the following statements:**

**The choice to seek treatment was completely my own.**

1	2	3	4	5	6	7
Completely disagree						Completely agree

**I felt pressured, coerced, or strong-armed into seeking mental health services.**

1	2	3	4	5	6	7
Completely disagree						Completely agree

**I bounced around without clear direction until I eventually ended up in this treatment.**

1	2	3	4	5	6	7
Completely disagree						Completely agree

**I was led into treatment by others, without either agreeing or resisting.**

1	2	3	4	5	6	7
Completely disagree						Completely agree

**Use the following scale to indicate the extent to which each of the people below influenced your decision to access your current treatment:**

No influence	Little influence	Moderate influence	Strong influence
1	2	3	4

Me  
 People in my social circle (e.g., friends and family)  
 Medical professionals (e.g., primary care physicians, medical specialists, nurses)  
 The legal system  
 My workplace  
 Other (please specify): \_\_\_\_\_

*Now we have a few questions about your physical health.*

**How would you rate your overall physical health at the present time?**

1	2	3	4
Poor	Fair	Good	Excellent

**Do your physical health problems get in the way of you doing the things you want to do?**

1	2	3	4
No physical health problems	Not at all	A little	A great deal

**How would you say your physical health compares to most people your age?**

1	2	3
Not as good	About the same	Better

**Do you have any physical health concerns or illnesses (acute or chronic) that you are suffering from currently?**

No       Yes

**If yes, please indicate your physical health concerns:**

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*Now we'd like to ask you about how you have been feeling recently.*

***During the past 30 days, about how often did you feel:***

***...nervous?***

None of the time	A little of the time	Some of the time	Most of the time	All of the time
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***...hopeless?***

None of the time	A little of the time	Some of the time	Most of the time	All of the time
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***...restless or fidgety?***

None of the time	A little of the time	Some of the time	Most of the time	All of the time
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***...so depressed that nothing could cheer you up?***

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

***...that everything was an effort?***

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

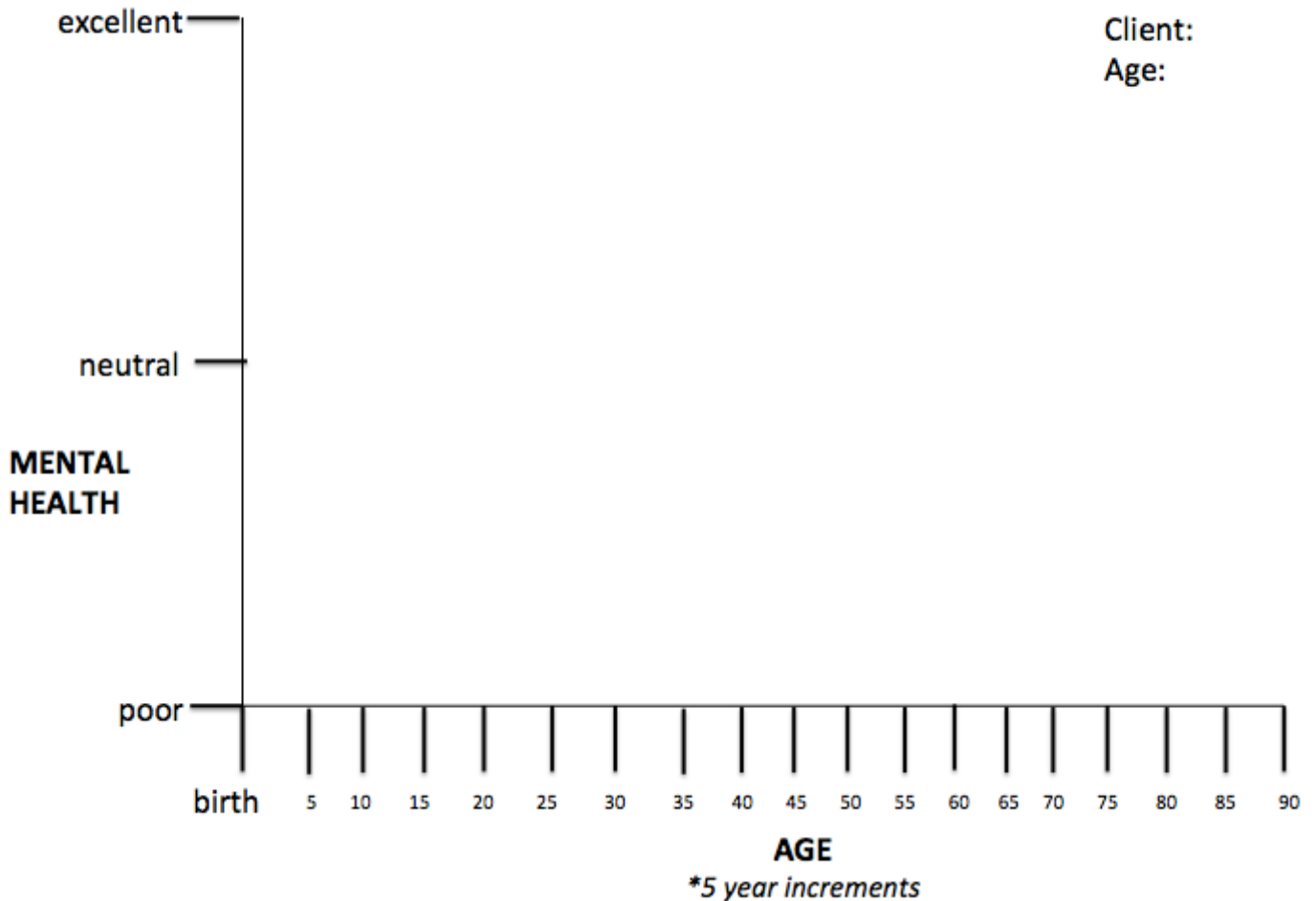
***...worthless?***

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------



*Thank you once again for agreeing to participate in the study. Now, before we begin the interview, I would like you to fill out this graph for me (show the graph). This graph illustrates how your mental health has been across your lifespan. On the left side, your mental health can fluctuate from poor, to neutral, to excellent, or anywhere in between. On the bottom of the graph is your age, going up in increments of 5 years. So, this is where you would be now (pointed to their age on the graph). For the majority of our interview, we are going to be talking about what currently brings you in for treatment at \_\_\_\_\_. Near the end of the interview, I will ask you about your past experiences with mental health. So, this graph will be used as a tool to help you recall some of those times when your mental health worsened, improved, or stayed the same. Your illustration doesn't have to be perfect or exact, it is just meant to give us a general sense of changes in your mental health. Do you have any questions? (Gave them a pen, they drew their graph, handed it back to me). Thank you! Ok I will set this aside until the final part of our interview.*

**Mental health throughout the lifespan**



## Appendix F

### Interview Protocol (Mackenzie, ongoing)

#### Initial Open-Ended Questions:

\*Focus on most recent service use experiences

\*If participants have had several times in their lives where they have sought out mental health services, focus on most recent service use experience first, then, prior to ending the interview, ask about the first time they sought help, examining any differences between that prior episode and current episode

\*Flesh out three pathways to services:

1. Choice: the choice to seek treatment was primarily or completely their own; a sense of agency or self-efficacy in decision making
2. Coercion: feeling pressured, coerced, or strong-armed into seeking help by friends, family, coworkers, the legal system, etc
3. Muddling through: drifting around the mental health system without clear direction before entering treatment; being led into treatment without either agreeing or disagreeing; being unsure of how they ended up in treatment

#### Tell me about how you came to seek help at \_\_\_\_\_ (clinic) for \_\_\_\_\_ (mental health problem)

- When did you first notice difficulty with \_\_\_\_\_ (mental health problem)?
- What was that like? What did you think? What were you feeling? What did you do first? What did you do next?
- How long did it take after you first began struggling with \_\_\_\_\_ problem until you decided to talk to someone about it?
- Would you say you were willing or reluctant to seek professional help? Why?
- Who were the various people you consulted with for help or advice as you were seeking help for this problem? How did these people influence you?
  - Be sure to ask about the influence of informal social network (fam/friends), formal network (professionals), and others (eg employer)
- What contributed to your coming to this clinic?
- Did anyone or anything get in the way of your seeking help? In what ways?

#### Pathways to treatment:

- To what extent would you say that the choice to come to this clinic was yours? Another way to think about this is in terms of who was driving the decision to seek treatment? Were you the sole or primary driver? Or would you say you were in the passenger seat with someone else driving the decision? Or perhaps you were in the back seat and had little say in the decision to come here?
- Did you, at any point, feel you were pressured, coerced, or strong-armed to seek professional help for \_\_\_\_\_ (mental health problem)? Was there someone you were worried about disappointing if you didn't come here?
- Was there any point, while you were struggling with \_\_\_\_\_ and trying to get help, that you felt you were muddling through or lost in the mental health system? Did you ever feel like you were drifting around the system without clear direction? Or that you were led into treatment by someone without either taking control or actively resisting? If so, who led the way?

**What did you know about \_\_\_\_\_ (mental health problem) and treatment options before coming to \_\_\_\_\_ (clinic)?**

- Where did you get that information from?
- Do you feel more informed than you did when you started experiencing symptoms?
- Would you have made different treatment choices knowing what you know now?
- What do you wish you would have known about \_\_\_\_\_ (mental health problem) and \_\_\_\_\_ treatment/clinic before seeking services?
- What might have helped you make treatment decisions? Who might have helped? In what ways?
- What are the important lessons you learned about seeking treatment? What advice would you give someone who is struggling with \_\_\_\_\_ like you were?

**How has your experience seeking treatment impacted you? Has it been a good experience? What could have made it better?**

### Previous Help-Seeking

**Now for the last 10 or 15 minutes, let's take a look back at the graph you completed earlier, and focus on your mental health throughout your life. Have you had previous experiences seeking mental health services from a mental health or health professional?**

- When did you seek that help (pointing to graph)?
- What kind of treatment did you access? Was it helpful?
- Did your previous experiences with mental health professionals influence how you sought treatment for \_\_\_\_\_ (current mental health problem)?

**If there were low points on the graph that the person didn't seek help: Why didn't you seek professional help at this point/these points in your life?**

#### **Pathways related to previous help-seeking**

- When you sought professional help in the past, to what degree were your treatment decisions mostly or entirely your choice?
- In your previous treatment-seeking did you experience any pressure, coercion, or strong-arming?
- In your previous experiences did you feel lost or that you were muddling through the system?

**Is there anything you would like to say before we end the interview?**

- Anything you would like to ask me?