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The Impact of Psychosocial Factors on Experience of Illness and Mental Health Service Use

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Mental illness in psychiatry is a world of diseases, symptoms and treatment. When conducting clinical interventions with older adults who have a mental illness, clinicians strive to provide adequate pharmacologic and psychotherapeutic interventions to alleviate suffering and promote recovery. Yet we are frequently faced with the dual challenges of underutilization of mental health services by older adults and nonadherence to the interventions offered. It is these challenges that spur us to look beyond symptoms and the need for treatments to the broader context of the individual. Psychosocial factors influence whether older adults seek and accept mental health interventions. These factors play a powerful role in adherence to interventions, and ultimately, depression outcomes. Similarly, attitudes and beliefs about mental illness can promote resilience or exacerbate symptoms in a suffering individual.

In an overview of the priorities for the National Institute of Mental Health there is evidence of a renewed interest in the individual perspective and the impact of psychosocial factors. The clinical vision offered by NIMH outlines the four “Ps” of medical research; they are prediction, pre-emption, personalize, and participation (<http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml>). To personalize research is to highlight “the individual biological, environment, and social factors”. This new emphasis may path the way for greater attention to the personal and psychological perspectives on mental illness. When we consider older persons’ access and use (or lack thereof) of services or treatments, we can view their choices as driven in part by social-psychological factors that either facilitate or hinder quality care.

Much is learned about the individual psychological perspective of older adults with depression by conducting research out in community settings. When you speak with older adults outside mental health settings, they openly talk about their reluctance to seek mental health care. They do not perceive the need for treatment, either because they attribute their difficulties to aging or medical illness, or perceive the ‘cost’ of treatment too high. The ‘cost’ goes beyond the finances of health care. It is the anticipated social costs of stigma and isolation. For many of these elders, mental illness is not like pneumonia with symptoms such as shortness of breath that cause distress, are readily identifiable as ‘abnormal’ and precipitate seeking care. Instead, many depressed older persons struggle to get moving, take care of themselves and their families, and manage their day to day affairs (from their perspectives). They do not perceive themselves as suffering from a mental illness (our term). As a natural consequence, these older persons do not see that their difficulties could be ameliorated by seeking and participating in care. Many elders perceive their distress as an intractable part of the aging process. If depression, medical illness and losses are a normal part of aging, why would one think to seek help?

The Anderson Behavioral Model of Health Service Use is an explanatory model for the use of health services. Individual factors that affect use of interventions include need, enabling factors, and predisposing factors ^[1, 2]. Need reflects both perceived and clinically -

evaluated symptoms. Enabling factors include family and community resources (e.g., financial, transportation). Predisposing factors are health beliefs, perceptions and misperceptions. This model provides a way of conceptualizing the multidimensional influences on health service use. Inequitable access occurs when the social structure, negative health beliefs and enabling resources determine care. While clearly a schema that omits relevant details, the Anderson Model [3, 4], provides a framework for considering the role of psychosocial (predisposing) factors on care.

Seeking care is a health behavior that emerges out of an often “non-conscious cost benefit analysis” [5]. It is only when we ask older adults the rationales for their choices and about their experience that the attitudes and beliefs become clear. To accept a referral and participate in mental health treatment reflects a balancing of predisposing factors, enabling factors and perceived need for care. Clinicians are aware of the barriers older adults face due to transportation, lack of mental health parity in insurance costs, and the impact of medical illnesses. But often these factors obscure the attitudes and barriers that may be equal determinants. For older adults with depression, the low energy and resignation resulting from symptoms, cognitive deficits and associated disabilities compound the potential psychosocial barriers [6]. In our work with community-dwelling clients of senior services, we have found that half of elders who are depressed do not perceive themselves as suffering from an emotional illness [7]. Many express concern about the social costs of being stigmatized for seeking depression treatment. Even among those elders who do initiate care, perceived stigma is a barrier to both participation in treatment and antidepressant adherence [8]. When teased apart, beliefs about depression, preferring self-reliance and lack of knowledge about services can contribute mental health service use, even after a hospitalization[9].

Additionally, barriers to using mental health care may reflect cultural assumptions about need and mental health care [10]. Concerns about stigma, fear of involuntary hospitalization and reluctance to divulge personal information are common among minority elders [11, 12]. Based on resilience theory, the individual level reluctance to seek care among minority seniors may reflect effective coping mechanisms and adaptations to surviving poverty, racism and discrimination into later years that now have become obstacles to health care [13, 14]. Preferences for self-reliance, use of home remedies, and care avoidance due to mistrust of care providers, may be powerful remnants from earlier healthcare abuses [13–15]. In these cases, the predisposing factors that once served to protect the individual have now become a barrier to care.

The papers included in this collection remind us that the personal and psychological perspective of mental illness and use of health care is very powerful. All of the papers culminate with a prescription to examine the context of the individual to better understand the complex experience of mental illness and seeking treatment. Each paper acknowledges that while we bring together symptoms to classify diseases, the impact of the disease on the individual is dependent on more than just the symptoms. It is the psychosocial factors that may determine the experience of the disease, whether care is sought and the effect on the person.

The first two papers address the impact of mental illness on individuals’ lives. They explore the impact of stigma and functioning through the personal lens of the individual. Sajatovic and colleagues[16] use a qualitative, semi-structured assessment to explore the experience of living with bipolar illness among persons in treatment. They document the personal narrative of living with mental illness on identity, life goals and trajectory among a mixed aged sample. The interviews elicit the multiple levels on which individuals experience stigma, including the interface of stigma and culture.

McGibbin and colleagues^[17] explore participation in society as a specific component of disability. They examine the relation of individuals' participation and illness characteristics. They find an association of depression and restricted participation cutting across age ranges. The authors note that while they are unable to untangle whether depression leads to restriction, or restriction to depression, that the participants face their struggle with illness in a culture that limits the participation of individuals with mental illness.

The second set of papers explores the psychosocial factors related to suicide. Britton et al.,^[18] explore the relation of reasons for living to suicidal ideation among elders already receiving mental health care. They find that fears of suicide may be important deterrents to suicidal ideation. However, they also find that the relation between hopelessness and severity of suicidal ideation was stronger among elders with greater family responsibilities, suggesting that social involvement exacerbates stress in this case, rather than buffers it. They note the importance of exploring patients' motives for livings, rather than assuming the meaning of family responsibility.

Pompili et al.,^[19] contrast the experiences of younger and older adults who have committed suicide using psychological autopsy methods. They find that half of the suicides are depressed, but not all. Among the elders, living alone, being retired and less education is more common than among younger adults who die from suicide. The authors find, as previously documented, that 40% of the elders had seen a family physician. They emphasize the need to educate physicians about the risk of loneliness and depression. Yet, family physicians may also struggle with the same misattributions of the expectable costs of aging. Neither primary care patient, nor physician is able to perceive the need for psychiatric services. The misperceptions, beliefs and attitudes that older adults frequently hold, are also found among providers and family.

In sum, to advance our understanding of use of mental health services and the impact of disease on individuals, families and communities, we need to take a perspective that goes beyond the presentation of 'need'. It appears insufficient to document that symptoms exist. Instead, we need to understand how older adults perceive these symptoms, what they believe will help and what the impact of help has on their lives. This personalized perspective will enable us to better tailor our current interventions for individuals and offer opportunities to develop novel interventions that are better suited to our fast growing older adult population.

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